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health for all now!

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Introduction

HARSH SETHI

FROM THE ALMA ATA DECLARATION (1978) which gave the world the slogan 'Health for All by 2000 AD' to the People's Health Assembly in Bangladesh (December 2000) represents a long journey, both chronologically and metaphorically. In more ways than one these two decades have witnessed a radical transformation of the world – the collapse of the erstwhile Soviet Union and the concomitant decline of Communist ideology, frameworks and even values; the veritable hegemony of market-oriented frameworks as the governing principles for all activities; the rise to dominance of the US as the sole superpower advocating its favoured policies worldwide; and above all, a declining faith in the state as the appropriate mediating agency to subserve the interests of all citizens, in particular those relatively assetless and 'voiceless'.

Alongside we have experienced a growing power of global capital with multinational corporations in both product and services dominating not just global exchange but modulating national policies to subserve their private, commercial interests. The expansion of the erstwhile GATT framework into the WTO regime bringing under its ambit new commodities, services, investment flows and even intellectual property regulations has further squeezed autonomous national space for policies and experiments seeking to follow alternative paths.

Expectedly all this is a far cry from the international environment prevailing at the time of the Alma Ata Declaration. If anything, the late 70s saw the flowering of a framework that while reiterating the duty of the state in the provision of public goods and services strongly advocated the involvement of communities to modulate the rigidities and bureaucratic inefficiencies of staterun systems. In the field of health and medicare, strong linkages were established between poverty, inequality and health and practitioners

highlighted the role of education, nutrition, clean drinking water, sanitation and so on to ensure declines in infant mortality, death rates and morbidity.

Even technical medicare – the role of doctors and medicines – came under increasing scrutiny, with critics highlighting the importance of primary healthcare over sophisticated tertiary treatment centres. Equally, there was the effort to demystify modern medicine and the role of health professionals both by recognising the importance of and legitimising traditional medicinal systems and healers as also, through a variety of training programmes, reinstating people's health in people's hands. Simultaneously there was a global movement to nudge respective governments into increasing budgetary provisions for healthcare, with public provisioning programmes and primary healthcare being foregrounded over specialist institutions.

It is not that the trends of the last two decades, which many critics have termed retrogressive, were either uni-directional or went unchallenged. The 80s and 90s also witnessed the flowering of alternative discourse and practices keeping alive the objectives of equity and autonomy and challenging the tendency of viewing patients as mere consumers of specialist products and interventions. And while the essential locus of alternative praxis remained in the ex-colonial Third World countries, driven both by considerations of equity and participation as also the need to keep unit costs low, the sector of modern medicare grappled with new concerns of medical ethics and rights of patients. Equally as the costs of modern medicine and healthcare spiralled, countries had to experiment with new modes of financing and insurance.

The People's Health Assembly, a campaign for 'Health for All – Now,' built on the numerous efforts encompassing all elements of healthcare that have sought to democratise health and return it to where it properly belongs, in the hands of the common people. It came as a valuable corrective at a time when the dice appeared impossibly loaded in favour of the global healthcare industry dominated by MNCs and First World models totally inappropriate to addressing the concerns of common people. This issue of *Asian Exchange* presents a selection of crucial presentations and reflections on the exercise.

Several members of ARENA, an Asian network of concerned and engaged scholar-activists, were integrally involved in various capacities in the PHA, both the final event as also the many run-up meetings and intense preparations. It is particularly apposite that the meeting was held at Savar (Bangladesh), the headquarters of one of the most significant healthcare experiments in the region, if not worldwide. For close to three decades now, Gonoshasthaya Kendra (GK) has been a forerunner in alternative, people-centred healthcare, not only in the provision of low-cost, high-quality services with the central participation of para professionals, the setting up of a pharmaceutical factory to produce generic medicines, the design and running of

alternative medical education, but demonstrating through practice the integral link between improved health status, livelihood provision, and education, particularly of women. Equally it has struggled, albeit with mixed success, to democratise national health policy.

* * * * *

The issue opens with a brief note by Dr Ravi Narayan on the PHA reminding us of the often forgotten but still relevant Alma Ata Declaration. He underscores the importance of the Global People's Health Charter – endorsing health as a social, political and economic issue and a fundamental human right; identifying inequality, poverty, exploitation, violence and injustice as the roots of ill-health; the imperative of challenging powerful economic interests, globalisation in its current form and political and economic priorities; bringing in the voices of the poor and marginalised and encouraging people to develop their own solutions and encouraging people to hold authorities – local, national, global – to account. Equally he highlights the process behind the PHA – the many prior events, particularly the Jana Swasthya Sabha in Calcutta, which helped bring close to 1,500 people to Savar.

'Liberation from What: A Critical Reflection on the PHA2000' by David Werner and David Sanders, goes beyond reportage and endorsement to examine both the many successes but also limitations and failures of the event and process. This is relatively rare for we often do not get self-critical reflections, particularly from practitioners who share the objectives. Werner, best-known for the remarkable *Where There is No Doctor*, based on his work in Mexico, and his colleague highlight some of the 'mistakes' of the process for else 'we will miss the chance to learn from our mistakes and do better in the future.'

He is warmly appreciative of the choice of the venue, the remarkable effort in housing and feeding the delegates, the many rich 'informal' discussions and so on. As an exchange of varied experiences and an effort at forging solidarity among all those wedded to a people-centred development and health process, the PHA was unparalleled. So was the pre-PHA event in Calcutta, which managed to attract an even larger number of over 10,000 people.

Nevertheless, the authors are critical about 'the preordained lack of direction, in both content and facilitation,' what they classify as an absence of strategic planning. In the event, the PHA failed to develop an analytic comprehension, even less advance practical suggestions for specific actions. In addition, despite a framework that stresses that 'health is determined more by social, political, economic and environmental factors than by medical

services or public health measures *per se*,' these other sectors were inadequately represented.

Equally disturbing was the tendency to fall prey to rabble-rousing rather than welcome reasoned debate, exemplified for instance in the veritable boycott of World Bank professionals invited to address the plenary. These, in conjunction with technical drawbacks like lack of translation facilities and poor overhead projections, meant that many participants were kept out of the deliberations.

Werner and Sanders end with a range of suggestions to carry forward and deepen the process so that the impetus generated at the PHA does not dissipate.

The two contributions on the PHA process are followed by a brief report on an incident involving noted anti-pesticides campaigner Dr Romeo F Quijano and his daughter Ilang-Ilang, who had published an article in the *Philippine Post* exposing the activities of a banana plantation, Ladeco, in the Mindanao region. The plantation, in addition to violating labour laws, created major environmental hazards through an indiscriminate use of pesticides affecting villages close by.

Not unexpectedly, Ladeco, rather than accept its corporate responsibility sued the authors for criminal libel. Fortunately, the charges were dismissed; otherwise father and daughter may have had to spend a long time in jail.

'Health, Healthcare and People-centred Social Development' by Huang Ping presents some preliminary research findings from a relatively under-reported and studied region – the Tibetan enclaves in Yuannan province of China. Huang points out the many practical and conceptual difficulties in designing and implementing development policies in a 'secluded, chilly, poverty-stricken area' that too peopled by a minority. Since the development model followed draws on the experiences of the more 'advanced' coastal regions of the country, the catching-up process imposes severe environment, social and health costs. He also argues against a business-oriented model of social insurance and pleads for a community-based healthcare system.

While the region has shown significant improvements, particularly in longevity, and care has been taken to integrate Chinese and Western medicine with traditions of Tibetan medicine, given the specificities of the region (poverty, sparse population) even small illnesses can become serious. Further the region is experiencing new diseases post greater integration with the rest of the society.

The subsequent two papers 'Competition Promotion and the Prices of Drugs and Medicines' by Orville Solon and Eduardo Banzon and 'Patents vs Patients: AIDS, TNCs and Drug Price Wars' by Kavaljit Singh focus our attention on the problem of expensive drugs and medicines, the policies

followed by drug MNCs and Pharma giants and the differential pricing policies followed in different countries, all for maximising profits without due concern for people's health and capacity to pay.

Solon and Banzon discuss how lack of competition creates pricing anomalies which, combined with irrational drug prescription and use, generate health hazards. However, more than advocate a state takeover of drug production and distribution they recommend a competitive structure of retail trade.

Singh's article discusses some implications of the recent famous case where the South African authorities were taken to court by a group of pharmaceutical TNCs for violation of new patent laws in the case of medicines for treatment of AIDS. Given the high incidence of AIDS in South Africa and the high prices of AIDS drugs, the government decided to both manufacture and import cheaper versions of drugs whose patents were controlled by foreign drug companies. The increase in competition as also parallel imports resulted in substantial price reduction.

It so happens that as a result of a major campaign by health activists and groups and the negative publicity generated, the affected companies decided to withdraw. Nevertheless the campaign exposed the unethical practices of drug MNCs and the questionable role of the US administration in particular, in the attempt to uphold the validity of the TRIPS agreement under the WTO regimen. Incidentally, the recently-concluded Doha ministerial to discuss new WTO rounds has accepted the need to place restrictions on TRIPS in the case of generic medicines needed to combat epidemics. Singh argues that this 'victory' must be taken forward and that national governments must enact suitable legislation to enable access to cheaper drugs for common people.

Finally we have an evocative recounting by Aditi Chowdhury of the Gonoshasthya Kendra, the site for the PHA and the 'People's Charter for Health'. These pieces are linked because the history of GK encapsulates many of the crucial debates and struggles in evolving an understanding and practice of people-centred healthcare, the aim of the charter.

It is our hope that this brief collection will stimulate a debate among all those not only struggling against the iniquitous policies advocated and practised by the medical establishment but seeking to evolve and establish viable alternatives at a socially significant scale.

The People's Health Assembly

A People's Campaign for HEALTH FOR ALL – NOW!

RAVI NARAYAN

IN 1978, an International Health Assembly at Alma-Ata in the USSR, co-sponsored by the World Health Organisation (WHO), United Nations' Children's Emergency Organisation (UNICEF), and others, gave the World a slogan – *Health for All by 2000 AD* – and endorsed the famous *Alma Ata Declaration*, that brought people and communities to the centre of health planning and healthcare strategies, and emphasised the role of community participation, appropriate technology and intersectoral coordination. The declaration was endorsed by all the governments of the world and symbolised a significant paradigm shift in the global understanding of Health and Healthcare.

Twenty two years later – after much policy rhetoric, some concerted but mostly ad hoc action, misplaced euphoria, assault and distortions by the growing market economy of medicine and a lot of governmental amnesia – this declaration remains unfulfilled and mostly forgotten, as the world comes to terms with the new economic forces of globalisation, liberalisation and privatisation which has ensured that health for all is a receding dream.

The People's Health Assembly in Savar, Bangladesh, during December 4-8, 2000, preceded by a series of pre-assembly events all over the world, including the Jana Swasthya Sabha (National Health Assembly) at Calcutta, India, over November 30-December 1, was a civil society effort to counter this global amnesia and challenge health policymakers around the world with a *People's Health Campaign for Health for All – Now!*

About 2,000 delegates arrived in Calcutta, mostly by five people's health trains, bringing with them ideas and perspectives from 17 state conventions and about 250 district conventions that covered representatives from about 1,000 community development blocks in the country. At the Calcutta assembly, delegates endorsed an *Indian People's Health Charter*, apart from spending

two days together collectively sharing their commitment to the Health for All campaign by participating in parallel workshops, sub-conferences, exhibitions, a march for health, a public rally, and cultural programmes celebrating national diversity and cultural plurality.

Later about 200 delegates from the National Health Assembly travelled, mostly by bus, to attend the global health assembly at Savar, Dhaka. Here they joined 1,453 people from 92 countries, in an unusual five-day event, bringing together people's concerns about the unfulfilled Health for All challenge. The assembly included a march for health, meetings at which the health situation from many parts of the world and struggles of people were shared and commented upon by multidisciplinary resource persons, parallel workshops to discuss a range of health and health-related challenges, cultural programmes to symbolise the multi-regional, multicultural and multiethnic diversity of the peoples of the world, exhibitions and video/film shows and dialogue, in small and big groups, using formal and informal opportunities.

Finally at the end of a whole year of mobilisation and two very intense interactive assemblies in Calcutta and Savar, a *Global People's Health Charter* emerged and was endorsed by all the participants. This charter has now become an expression of common concerns, a vision of a better and healthier world, a call for radical action, a tool for advocacy for people's health, and a rallying point for global health movements and networks and coalition-building.

The significance of the Global People's Health Charter are many.

- Firstly it endorses that Health is a social, economic and political issue and a fundamental human right.
- Secondly it identifies inequality, poverty, exploitation, violence and injustice as the roots of ill-health.
- Thirdly it underlines the imperative that Health for All means challenging powerful economic interests, opposing globalisation in its existing iniquitous model, and drastically changing political and economic priorities.
- Fourthly it tries to bring in perspectives of voices of the poor and marginalised (rarely heard) encouraging people to develop their own local solutions.
- Finally it encourages people to hold accountable, their own local authorities, national governments, international organisations and corporations.

The vision and the principles, more than ever before, extricates Health from the myopic biomedical-techno-managerialism of the last two decades,

with its vertical, selective magic bullets approach to health, and centres it squarely in the context of today's global social-economic-political-cultural-environmental realities. However, the most significant gain of the PHA and the Charter is that, for the first time since the Alma Ata Declaration (1978), a Health for All action plan unambiguously endorses a call for action that includes:

- Health as a human right
- Economic challenges for health
- Socio-political challenges for health
- Environmental challenges for health
- Tackling war, conflict and violence
- Challenges in evolving a people-created health sector

This comprehensive view of Health action, as we enter the new millennium, is probably the most significant gain of the PHA process.

The PHA process at National and Global level had many other gains as well. For the first time in decades, health and non-health networks have come together to evolve global and national solidarity and collectivity in health. In India, this included the All India People's Science Network (AIPSN); All India Drug Action Network (AIDAN); Asian Community Health Action Network (ACHAN); All India Democratic Women's Association (AIDWA); All India Women's Conference (AIWC); Bharat Gyan Vigyan Samithi (BGVS); Catholic Health Association of India (CHAI); Christian Medical Association of India (CMAI); Forum for Crèche & Child Care Services (FORCES); Federation of Medical Representatives Associations of India (FMRAI); Joint Women's Programme (JWP); Medico Friends Circle (MFC); National Alliance of People's Movements (NAPM); National Federation of Indian Women (NFIW); National Association of Women's Organisations (NAWO); Ramakrishna Mission (RK); Society for Community Health Awareness, Research and Action (SOCHARA); Voluntary Health Association of India (VHAI).

In most states of the country, the state-level links of the above national networks came together with regional and local networks, to join the process.

At the global level, eight well known international networks and resource groups worked together for the first time. These included International People's Health Council (IPHC); Health Action International (HAI); Consumer International (CI); Asian Community Health Action Network (ACHAN); Third World Network (TWN); Women's Global Network for Reproductive Rights (WGNRR); Gonoshasthaya Kendra (GK) and Dag Hammerskjold Foundation (DHF). By the end of the mobilisation process they were joined by a host of

institutions, networks and resource groups from all over the world. This national and global collectivity and solidarity was significant and must be maintained.

Another significant development was that this evolving solidarity found symbolic expression in six documents at the national level and three documents at the global level. In India there are five booklets entitled:

i) *What Globalisation does to People's Health*
ii) *Whatever happened to Health For All by 2000- AD?*
iii) *Making Life Worth Living*
iv) *A World Where We Matter*
v) *Confronting Commercialisation of Health Care*
vi) *The Indian People's Health Charter.*

At the global level

i) The discussion paper *Health in the Era of Globalisation – from Victims to Protagonists*
ii) The discussion papers on
    a) *The Political Economy of the Assault on Health*
    b) *Equity and Inequity Today: Some Contributing Social Factors*
    c) *The Medicalisation of Healthcare and the Challenge of Health for All*
    d) *The Environmental Crisis: threats to Health and Ways Forward*
    e) *Communication as if People Mattered: Adapting health promotion and Social Action to the Global Imbalances of the 21st Century*
iii) *The People's Charter for Health.*

These documents taken together represent an unprecedented emerging global consensus.

What is equally significant is that the mobilisation for the PHA process was not just event-oriented but was preceded by a range of grassroots, local and regional initiatives. For example in India, it included people's health enquiries and audits; *kalajathas* – health songs and popular theatre; policy dialogue; block level seminars; translation of the consensus national documents into all the regional languages; campaigns to challenge medical professionals to become more Health for All-oriented; and people's trains that did not just transport health activists to the national event but also became travelling workshops and opportunities to increase health awareness during the journey, at many stations, with slogans and songs. Similar initiatives, though less intense, perhaps took place in Bangladesh, Nepal, Cambodia, Philippines, Japan, China and other parts of the world including Latin America, Africa, Europe (from England to Latvia, Russia and Ukraine) and West Asia.

Perhaps the most significant gain, however, is not all that took place before the events and at the events, but what seems to be going on after the December 2000 assembly euphoria had died down.

At a global level, the translation of the People's Health Charter into several languages and its use for lobbying has been an important development. Arabic, Chinese, Dutch, French, Finnish, German, Greek, Japanese, Russian, Spanish, Swedish, Ukrainian, Urdu, ... the list goes on (29 languages so far). Videos for public education on the events and issues are evolving, including the BBC–Life Series video on *The Health Protestors*. Lobbying efforts, including the presentation of the People's Health Charter, is taking place in national, regional and international fora, including the WHO and the World Health Assembly. Public meetings, taking the Health to the Streets campaign as a Rights issue, discussions on the charter by professional associations and editorials in medical/health journals, and policy dialogues are beginning to happen. *Every day the list of follow-up action increases.*

To conclude, the People's Health Assembly process was a rather unusual multi-regional, multi-cultural, and multi-disciplinary mobilisation effort that brought together the largest collections of activists and professionals, civic society representatives and the people's representatives themselves, to evolve a global instrument of concern and action, and express solidarity with the health struggles of people and the marginalised in today's iniquitous and unhealthy global economic order.

Recognising that we need each other in a continuous, sustained, collective effort, the PHA process must remind us, through the People's Health Charter, that a long road lies ahead in the campaign for Health for All – Now! The People's Health Assembly at Calcutta and Dhaka, were only the end of the beginning!

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For more information and access to documents and reports please refer to:

- PHA website – International (www.pha2000.org)
- PHA website – Indian (www.tnsf.org/pha)
- CHC website (www.geocities.com/sochara2000)

PEOPLE'S CHARTER FOR HEALTH

PREAMBLE

- Health Is A Social / Economic / Political Issue
- Fundamental Human Right
- Inequality, Poverty, Exploitation, Violence And Injustice Are At Roots Of Ill Health
- **Health For All** Means
  - Challenge Powerful Interests
  - Oppose Globalisation
  - Drastically Change Political And Economic Priorities
- **Charter Builds On**
  - Perspectives Of Voices Rarely Heard
  - Encourages People To Develop Their Own Solutions
  - Holds Accountable
    - Local Authorities
    - National Governments
    - International Organisations
    - Corporations

1

PEOPLE'S CHARTER FOR HEALTH

VISION

- A World with Equity, ecologically sustained Development and Peace
- A world in which a healthy life for all is a reality
- A world that respects, appreciates, and celebrates all life and diversity
- A world which enables flowering of peoples talents and abilities to enrich each other
- A world in which peoples voices guide the decision that shapes our lives

2

PEOPLE'S CHARTER FOR HEALTH

RECOGNISING HEALTH CRISIS

- Economic Changes Affecting Peoples Health And Access To Health / Social Services
- Poverty And Hunger Increasing
- Gaps Between Rich And Poor Nations Widened; Inequalities Within Countries Increasing
- Large Proportion Lack Access To Basic Needs (Food, Water, Sanitation, Land, Shelter, Education)
- Planetary Resources Being Rapidly Depleted
- Upsurge Of Conflicts / Violence
- Worlds Resources Increasingly Concentrated In Hands Of Few Who Strive To Maximise Their Profit
- New Economic / Political Policies Affecting Lives, Livelihoods, Health And Well Being Of Peoples In South And North
- Public Services Deteriorating, Unevenly Distributed And Inappropriate
- Privatisation Undermining Access And Equity Principles

3

PEOPLE'S CHARTER FOR HEALTH

PRINCIPLES

- Health Is Fundamental Human Right
- Primary Health Care (1978 Alma Ata Declaration) Basis For Policy
- Governments Fundamental Responsibility To Ensure Access And Quality
- People And Peoples Organisations Essential To Formulation, Implementation, Evaluation Of Health Programmes
- Political / Economic Social / Environment Are Primary Determinants Of Health And Must Get Top Priority In Policy Making
- Action At All Levels To Tackle Crisis
  - Individual
  - Community
  - National
  - Regional
  - Global

4

PEOPLE'S CHARTER FOR HEALTH

A CALL FOR ACTION - 1

HEALTH AS A HUMAN RIGHT

- Support attempts to implement the right to health
- Demand that governments and international organisations reformulate, implement policies that respect right to health
- Build broad based popular movements for incorporating health and human rights into national constitutions / legislations
- Fight exploitation of people's health needs for purposes of profit

5

PEOPLE'S CHARTER FOR HEALTH

A CALL FOR ACTION - 2

TACKLING ECONOMIC CHALLENGES

- Transformation of Global trading system, violating social / environmental / economic / health rights of people
- Demand cancellation of Third World Debt
- Demand Radical transformation of World Bank and IMF
- Counter WTO / TRIPS Regimes that distort public health
- Effective Regulation of TNCs
- Ensure agricultural policies that are attained to peoples needs not market demands
- Economic policies to be subject to health, equity, gender and environmental impact assessments
- Challenge growth-centred economic theories and promote alternatives that create humane and sustainable societies

6

PEOPLE'S CHARTER FOR HEALTH

A CALL FOR ACTION - 3

TACKLING SOCIAL / POLITICAL CHALLENGES

- Demand / Support comprehensive social policies
- Ensure all men and women to have
  - Equal rights to work
  - Livelihoods
  - Freedom of expression
  - Political participation
  - Religious choice
  - Education
  - Freedom from violence
- Protect / promote health and human rights of marginalised
- Demand Health and Education at top of political agenda
- Seek reversal of policies that result in forced displacement of people from lands / homes or jobs
- Oppose fundamentalist forces that threaten lives of women, children and minorities
- Oppose sex tourism and global traffic of women and children

7

PEOPLE'S CHARTER FOR HEALTH

A CALL FOR ACTION - 4

TACKLING ENVIRONMENTAL CHALLENGES

- Hold accountable all who destroy or support hazardous activities that impact on environment and Peoples health
- Demand health and environmental impact assessment of development projects
- Increase commitment to reduction of Green House gases
- Oppose shifting of hazardous industries and toxic / radioactive waste to poorer countries
- Reduce over consumption and non sustainable lifestyles
- Demand measures to ensure occupational health and safety
- Demand measures to prevent accidents and injuries at work place, community and in homes
- Reject patients on life and oppose biopiracy of traditional indigenous knowledge and resources
- Press for regular developmental audits that measure health status and environmental degradation.

8

PEOPLE'S CHARTER FOR HEALTH

A CALL FOR ACTION - 5

TACKLING WAR, VIOLENCE AND CONFLICT

- Support campaigns and movements for peace and disarmament
- Campaigns against aggression; and research, production and testing weapons of mass destruction
- Support peoples initiative to a just and lasting peace's in countries with experience of civil war and genocide
- Condemn use of child soldiers; and abuse, rape and torture of women and children
- Oppose militarisation of humanitarian relief interventions
- Democratise UN Security Council
- Prevent use of sanctions as instruments of aggression
- Encourage initiatives to declare cities and communities as areas of peace and free of weapons
- Support campaigns for prevention and reduction of aggressive and violent behaviour especially in men

9

PEOPLE'S CHARTER FOR HEALTH

TOWARDS A PEOPLE CENTRED HEALTH SECTOR

- Demand Comprehensive Primary Health Care Strategies
- Pressure governments to adopt, implement and enforce national health and drug policies
- Oppose privatisation of public health services and ensure effective regulation of private medical sector
- Encourage peoples power and control in decision making in health at all levels including patient and consumer right
- Recognise, support promote traditional and holistic healing systems and practitioners
- Demand changes in training of health personnel to become more problem oriented and practical based
- Demystify medical and health technologies and subordinate them to health needs of people
- Demand that research is people and public health oriented and respect universal ethical principles
- Oppose coercion in population and family planning policies and support sexual self determination

10

PEOPLE'S CHARTER FOR HEALTH

A Call to WHO

- Respond to challenges that benefit the poor
- Avoid vertical approaches
- Ensure intersectoral work
- Involve peoples organisations in WHO and WHA
- Ensure independence from corporate interests

11

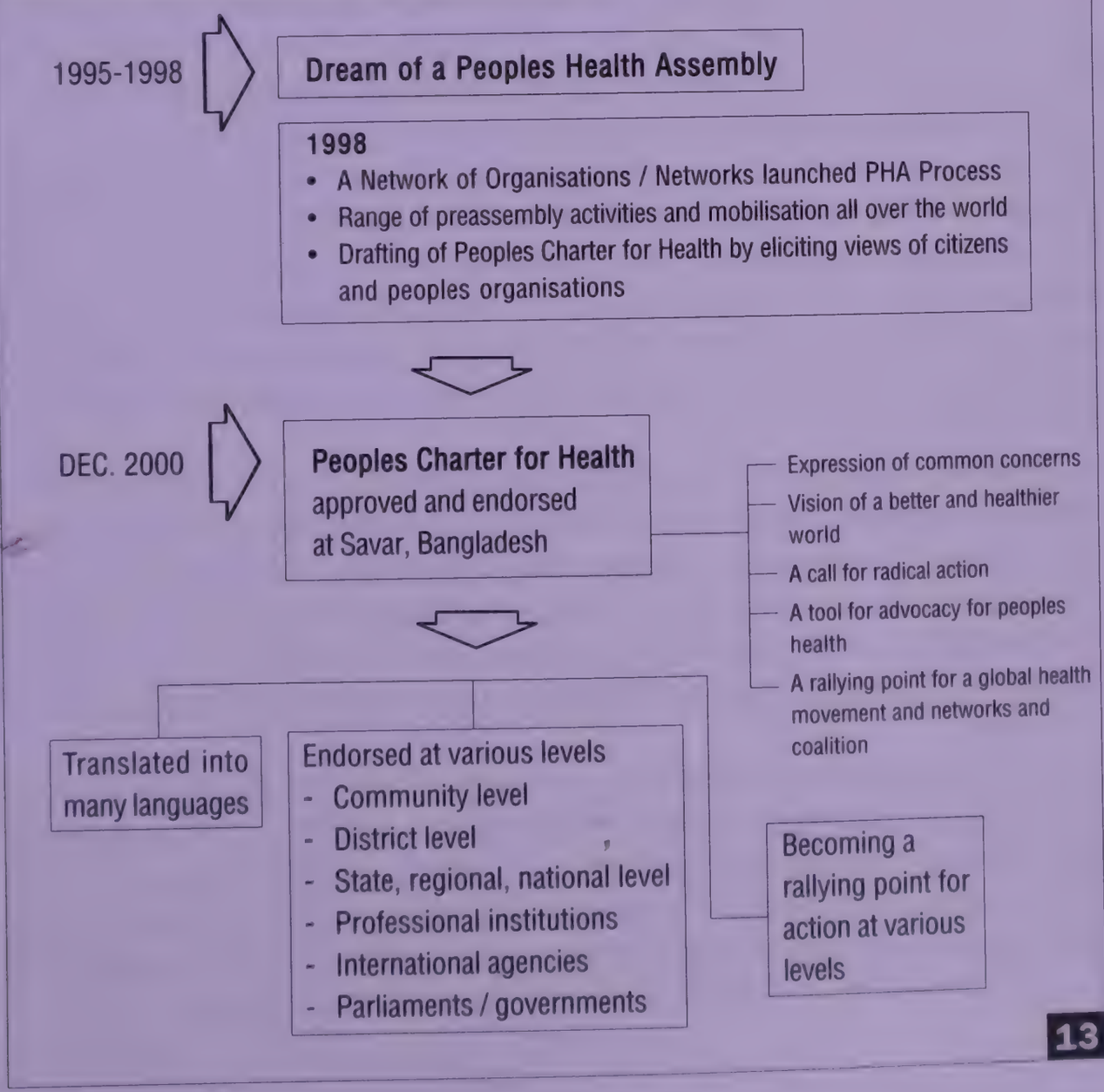
PEOPLE'S CHARTER FOR HEALTH

PEOPLES PARTICIPATION FOR A HEALTH WORLD

- Build and strengthen peoples organisation – basis for analysis and action
- Promote / support / encourage peoples involvement in decision making in public services at all levels
- Demand that peoples organisation be represented in
  - Local
  - National
  - International fora
- Support local initiatives towards participatory democracy and establish people centred solidarity networks

12

PEOPLE'S CHARTER FOR HEALTH



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Liberation from What?

A Critical Reflection on the People's Health Assembly 2000

DAVID WERNER & DAVID SANDERS

OVER THREE MONTHS HAVE PASSED since the first major international event of the People's Health Assembly (PHA) took place in Bangladesh, from December 3 to 8, 2000. Yet only now, after this long period of rumination, are we able to sort out our thoughts and feelings about this extraordinary event.

If, in this commentary, we are in some ways critical of the PHA event, it is not because we think it was unsuccessful. Rather it is because – given the enormity of the problems facing the world today – this momentous forum was only a tiny beginning of the necessary groundswell for change. Like each of us who took part in it, the event had its strong points and weak points. And if we all drown out each other's questions with unbridled applause, we will miss the chance to learn from our mistakes and to do better in the future.

Precisely because this first international event of the People's Health Assembly was not the final summit but rather the exuberant beginning of what we hope will blossom into a worldwide movement for change, critical reflection is essential. If we are to effectively forge a way forward, hindsight is as important as foresight. We must not just lampoon the global power structure. We must likewise be critical of our grassroots endeavour – and of ourselves.

One reason we are writing this assessment of the People's Health Assembly is that, at its closure, so many participants – in a knee-jerking response that was more reflexive than reflective – jubilantly declared it 'an overwhelming success.' This brought to mind a statement made by the philosopher Nietzsche to a doting audience, which was something like: 'I keep listening for whispers of understanding, but all I hear is shouts of praise.'

High Points of PHA2000

By many measures the PHA event was a roaring success. Nearly 1,500 people from 93 countries gathered at Gonoshasthaya Kendra (GK), in Bangladesh, to form a worldwide coalition of organisations and movements committed to work towards a healthier, more equitable, more sustainable world. The venue was well chosen. GK is one of the most revolutionary and inspiring community-based health programmes in the world. The physical and social ambience was fabulous! No five-star hotel for this huge forum: instead, a spacious auditorium was built behind the tranquil lakes and fields where the GK workers grow food for the community programme. Building the auditorium was no easy task. Due to heavy rains and tardy funding, two days before the event the vast structure still had no roof. But miraculously it was completed at daybreak the morning the Assembly began – thanks to the valiant efforts day and night of over 1,000 workers!

But how did the GK team manage to feed 1,500 people in this rural setting? Rather than bussing folks to restaurants or trucking in costly catered cuisine, they built a covey of small bamboo sheds and invited women from neighbouring villages to come prepare traditional food. The chance to perch out-of-doors on handcrafted bamboo stools, eating *chapatis* and *dhal* while trying to communicate with the gracious village women, was one of the high points of the Assembly. It somehow symbolised what we were collectively seeking to achieve: an innovative yet ancient way of transcending the commercial, hierarchical barriers that separate people from one another and their dreams. It brought us down-to-earth through the common understanding of each and everyone's most fundamental right, above all else: to have enough to eat.

It was during these communal meals, with six or eight of us activists and progressives from different parts of the world clustered around a table comparing our insights, that some of the most meaningful and potentially transformative interactions of the PHA took place. After attending countless international conferences and forums over many years, this was a marvellous opportunity to chew the fat with so many old friends and fellow warriors for social justice.

The energy and enthusiasm generated by the PHA was enormous! For all the diversity, the people present had in common a passioned commitment to change. Many were spokespersons for disadvantaged groups valiantly struggling to improve their situations – or at least to survive with dignity – in circumstances that in recent years have become more and more difficult and

oppressive. Needless to say, an enormous amount of pain, anger, and frustration was vented. But most important, a great sense of international solidarity emerged.

'TO GIVE THE VOICELESS A VOICE' was a foremost goal of the People's Health Assembly. And indeed, the PHA had strong representation from a wide spectrum of marginalised and underprivileged groups, many of whom had never before had a chance to speak at a local council, much less at an international forum. Speakers from all corners of the earth represented everyone from community health workers to traditional birth attendants, from mothers' clubs to a collective of unemployed alcoholics (from Scotland), from tribals to racial minorities, from migrant workers to refugees, and from commercial sex workers to activists with AIDS. A wide spectrum of NGOs ranged from grassroots movements to the Rockefeller Foundation.

Unfortunately, current leaders of the World Health Organisation and UNICEF were conspicuous by their absence. However, a big boost to the legitimacy of the PHA and its depth of discussion was provided by Halfdan Mahler (former Executive Director of WHO). Mahler was the guru behind the Alma-Ata Declaration in 1978, which set the worldwide goal of 'Health for All' – still our dream!

The PHA was a marvellous forum for sharing experiences and exchanging ideas. Events were enlivened by role plays, music, dancing, and poster sessions. Dramatic 'testimonials' of personal hardships – many of which brought tears to the eyes – portrayed the setbacks that people were suffering due to social injustice, unfair laws, and globalisation. To give more people a chance to speak out, literally hundreds of relatively small concurrent sessions were held, ranging from women's rights to genetic engineering and everything else under the sun.

One of the major achievements of the People's Health Assembly was the debate and collective approval of a 'People's Charter for Health.' The Charter declares social and legislative changes that are needed to put the basic needs of people before the profit interests of giant corporations. It calls for policies which promote the equity and balance essential to creating a healthy and sustainable world. It is hoped the Charter will help form the agenda for a broad-based people's movement that can pressure those in power – governments, the United Nations, WHO, and the international financial institutions (World Bank, IMF, and World Trade Organisation) – to work toward a paradigm of people-centred economic and social development that is conducive to Health for All.

Importance of Pre-Assembly Activities – Especially in India

In speaking of achievements of the People's Health Assembly, it is important to emphasise the many local and national pre-Assembly activities that prepared the way for the international event in Bangladesh. In many parts of the world, activists and NGOs held seminars, collected testimonials, gathered information, and prepared materials to involve and enlighten people about the underlying structural causes of ill-health, their roots in the top-heavy global economy, and the need for a massive uprising to demand healthier, fairer, more sustainable alternatives.

In September 2000 David Werner had the fortune to participate in a 'National Forum for Health of the People' in Ecuador. (This is described in the *Newsletter from the Sierra Madre* #43). Similar forums took place in Central America, Europe, Palestine, South Africa, the Philippines and Bangladesh.

But the largest, most incredible, pre-Assembly activity took place in India. In the weeks before the PHA event in Bangladesh, over a thousand Indian NGOs took part in a huge National People's Health Assembly in Calcutta. To mobilise mass participation and inform the citizenry of the issues involved, the organisers published a series of provocative, comic-book-like pamphlets. Written in the common languages of the people, these colourfully portrayed the root causes of poor health and their links to the global economy.

To transport the thousands of participants to Calcutta, facilitators organised four 'Health Trains,' which travelled across the country from different corners of India. At stops along the way, they held demonstrations, performed skits, and passed out flyers. In spite of all the careful planning, however, certain difficulties arose. Although carriages on the trains had been reserved weeks in advance, when participants gathered to board one of the trains, their reserved carriages were already full of passengers. 'Too bad!' said the Station Master. 'No room left for your group!' As the train began to pull out of the station without them, the activists lay down on the tracks in Gandhian-style resistance, preventing the train from departing. They refused to budge until the officials added more carriages and the Health Assembly activists could board!

The National People's Health Assembly in Calcutta was, as it turned out, much bigger than the international PHA event in Bangladesh. Over 10,000 people took part in the Calcutta event, and the 'People's Health March' through the city had over 20,000 people! In terms of widely communicating the core issues at stake – including how the global economy afflicts the health of people and the environment – in some ways India's pre-Assembly event surpassed the international Assembly in Bangladesh.

Shortcomings

Perhaps the greatest strengths of the People's Health Assembly were 1) building a sense of international solidarity, and 2) enabling a process of catharsis. People from disadvantaged groups around the globe had a unique chance to air their grievances... and did so with eloquence and passion.

But lamentation alone does not lead to liberation. Critical analysis, grassroots organising, and carefully planned strategic action do. Or at least they have a better chance of doing so.

Insufficient Direction

Some of us feel that the biggest weakness of the PHA event in Bangladesh was its preordained lack of direction, in both content and facilitation. While most of us had a general sense of where we wanted to go, and an embryonic vision of the people- and environment-friendly social order, there wasn't enough strategic planning about how to get there, not enough unifying clarification of key issues nor a comprehensive analysis of causes. Each day there was a plethora of concurrent and sometimes competing sessions, full of sound and fury. But their significance was muted by lack of feedback to the plenary sessions. It was hard to get a sense of where the Assembly was going, or what actions we might take.

Increasingly during the Assembly, a number of concerned participants, as well as progressive journalists, approached the steering group with worries that the analytic process seemed spotty and disjointed. Their big questions were, 'But where is all this leading?' and 'Yes, but how do we get there?' While utopian goals and sweeping demands were endlessly repeated, relatively few practical suggestions were made for specific actions that individuals and organisations could take.

Too Laissez-faire

One problem was balance. Although a set of carefully prepared background and issue papers had been written in advance of the Assembly, and although highly knowledgeable activists and even the authors of the papers were present and willing to contribute, little time was allotted in plenary sessions for analytic overview of the key issues or exploration of workable solutions.

In planning the Assembly's agenda it had been decided – rightly or wrongly – that it was more important to give lots of time for testimonials and input from those groups and participants who rarely have a chance to speak out. Indeed, we had argued strongly for giving plenty of time to their stories, ideas,

and suggestions. But, in retrospect, perhaps the pendulum swung too far in the direction of laissez-faire.

Some interpret this dilemma within the PHA process as springing from ideological differences, in which the PHA planning group was divided into two camps: First there were those who feel that in a forum for change everyone should be free to speak out as she or he wishes. Those who are usually silenced should be given the first chance. The process should be open-ended. Free speech is the path to liberation. They are willing to sacrifice a degree of structure and studied analysis for the sake of full and equal participation. The second group believes in a degree of guidance, or facilitation with a certain sense of direction. People have the right to hear the views and learn from the analysis of those who are more fully informed of the issues at hand. Thus a public forum should not simply be a 'free-for-all' but rather a well-planned educational process which can help guide people to come to realistic conclusions and formulate practical plans of action.

This is a strategic debate and there will be no easy answers. In today's world, perhaps more than ever, there can be no freedom without a strategy based upon thoughtfulness, responsibility and collective action. However, for better or for worse, the People's Health Assembly was programmed in a way that encouraged a lot of free expression of diverse experience and views. Unfortunately, it lacked sufficient facilitated direction – and unifying analyses – to carry it forward toward a workable plan of action. Although the last day was devoted to 'The Way Forward,' few people came away with a clear sense of what might be the next step that they or their groups could or should take. Speakers too often spoke in utopian generalities, such as, 'We must stop the World Bank from putting corporate greed before human need,' or 'Governments should regulate the health-endangering practices of the free market.' But rarely did they give any practical suggestions of how to convert these dreams into reality. There were lots of slogans and applause, but too little sense of direction.

With this critique, however, we do not mean to imply that there were no excellent speakers. Indeed, many were superlative and their presentations deepened our understanding of important issues. Missing was an integrated framework tying the main issues and presentations together, to keep the discussion moving forward rationally.

Not Sufficiently Multi-Sectoral

Another shortcoming of the PHA event was that it – in spite of our best intentions – was dominated by the health sector. Although we planners agreed and many speakers emphasised that 'health is determined more by social,

political, economic and environmental factors than by medical services or public health measures *per se*,' important sectors other than health were inadequately represented.

Indeed, some golden opportunities were missed. For example, Vandana Shiva – one of the world's leading activists for environmental sustainability as it relates to social justice – had agreed to come to the Assembly. (She had been urged to do so by her sister, Dr Mira Shiva, a member of the PHA steering group.) But because Vandana was not slated to speak at a plenary, she decided not to attend, rightly feeling she could make more of a contribution elsewhere.

For similar reasons the ground-breaking NGO, Partners in Health, which had hoped to present its eye-opening evaluation of the World Bank's Year 2000 *World Development Report* on 'Attacking Poverty,' also decided not to attend the Assembly.

Also absent among the speakers at the PHA plenaries were leaders in the field of alternative economics, such as the International Forum on Globalisation, and TOES (The Other Economic Summit). This is truly unfortunate. If the People's Health Assembly hopes to gain leverage in making the forces behind the global market more accountable to the world's people, it is imperative that the coalition it is trying to build embrace the full spectrum of sectors and movements that relate to human and environmental health and well-being.

Too Much Rabble-rousing: Not Enough Dialectical Debate *(Shouting down the World Bank)*

An internal confrontation on the third day of the PHA threatened to bring the entire Assembly to a screeching halt. Scheduled to speak was Richard Skolnik, Director of the World Bank's Regional Division of Health, Nutrition, and Population for Southern Asia. That morning, the Indian contingent at the PHA (more than 200-strong) decided to boycott the session. Although planners of the Assembly argued that they had invited Skolnik in hopes of an enlightening debate, the Indians were adamant that the World Bank had no place at the People's Assembly. The decision to invite the Bank, they said, had been made undemocratically by the planning committee, and it was the obligation of justice-seeking participants to protest it. The planning group suggested a middle ground. Fifteen minutes could be allotted before Skolnik was scheduled to speak. The planners could present their reasons why he had been invited. The Indians could present their grounds for his exclusion. Then the entire audience could decide by vote. This would permit a democratic decision about the inclusion of a woefully undemocratic institution.

But the possibilities for a middle ground solution were swept aside by Zafrullah Chowdhury, Director of Gonoshasthaya Kendra, who had personally promised Skolnik that he would be given a respectful, protest-free forum to debate the Bank's position. Consequently, when Skolnik rose to speak, the Indian contingent, spread out through the audience, stood up with jeers and placards of protest. Zafrullah jumped on the stage and shouted back. He tried to explain to the raging crowd that while the high-level summits of the World Bank fully merited demonstrative protests, and even civil disobedience, that it was uncalled-for to obstruct a mutual opportunity for dialogue and debate. Even on the battlefield there is a place for a truce, or time-out, to explore the possibilities of a less bloody way forward.

The shouting match continued for about 15 minutes. Then it suddenly quieted down and the audience allowed the World Bank spokesman to speak. The point had been made.

For many of us, paradoxically, this World Bank session turned out to be one of the most pivotal and educational events at the PHA. Some of us learned more from it than from any other session in the six-day Assembly. For example, to counter the arguments of the World Bank, the people's movements need to be much better informed and well-documented in what they say. Indeed, Skolnik made many excellent points, and cited numerous actions of the Bank's Health Division that appear strikingly similar to those advocated by the People's Health Charter. He stressed the importance of prevention, outreach to underserved areas, women's rights, provision of essential drugs, sustainability, and assurance that all people's basic health needs are equitably met. He gave examples of interventions where the World Bank has encouraged governments to invest more in primary healthcare than in costly tertiary care for the rich. A lot of what he said sounded disturbingly progressive. In fact, if we in the audience had not known the speaker was from the World Bank, we might have erred on the side of cheering rather than booing him – which of course everyone did.

It was not so much what Skolnik said, as what he carefully omitted saying, that revealed the wolf in sheep's clothing. While he stressed the importance of 'reducing poverty' as key to approaching Health for All, he failed to mention how World Bank policies outside the health sector have helped to concentrate wealth in the hands of transnational corporations and to widen the gap between rich and poor. He skirted around the negative impact of the Bank's 'structural adjustment policies' (SAPs) which – with their demand for privatisation of medical care and cutbacks in public spending – have made it harder for poor people to get the healthcare they need. In short, it is not what the speaker said, but what he didn't say, that showed the Bank's true colours.

After Skolnik sat down, three well-known critics of the World Bank and IMF were given the floor, and each made illuminating or provocative points. The most cogent arguments exposing weaknesses and inconsistencies of the World Bank were presented by David Legge, an Australian and key player in the International People's Health Council. It was unfortunate that much of the substance of David's talk did not receive the same attention as the two other speakers who, though they too made some penetrating observations, tended to be more committed to oratory than substance. To their statements like, 'The World Bank is an enemy of people! We must close them down!' the audience thundered jubilantly, 'Down with the Bank!'

Language and Communication

What was disturbing was that while some members of the audience were very tuned to the issues, others were more into applauding or hooting than careful listening. And sometimes they missed their cue. Sometimes they would clap when they should have gasped, and booed when they should have clapped. In terms of critical awareness (which is essential in the struggle for change) we still have a way to go.

In fairness, part of the problem was language. The plenary sessions were entirely in English, and then the range of accents and locution was such that even listeners whose first language was English had a hard time understanding. The Latin American contingent got so frustrated at being 'left out' that at one point they threatened to boycott the Assembly and to hold their own separate meeting instead.

It would have helped had the facilitators and speakers received guidelines in advance on basic methods of effective large-group communication. (David Werner had been invited to help lead a pre-conference session on this topic, but the invitation reached him so late that he had already a previous obligation. In the end, the session never took place.)

One method used to assist communication, especially for those with difficulty in English, was to use overhead projectors to show the script of key presentations on large screens. However, no guidelines had been given as to the size of print for projection. As a result, many scripts appeared in such small print that for much of the huge audience they were impossible to read.

Follow-up Action

Everyone agrees that the real success of the People's Health Assembly will depend on action and activities the participating individuals and groups manage to undertake after the Assembly. What small but significant steps will

we take that effectively contribute to building a fairer, healthier world – or at least a corner of it?

Potentially, one of the most positive outcomes of the PHA is the People's Charter for Health. It can provide a platform on which people can organise and lobby for change. But unfortunately, within the Assembly, the recommendations for mechanisms and actions to do this have not yet been clearly worked out.

Perhaps this is as it should be. Circumstances in different countries and communities differ widely. Approaches to problem-solving must be adapted accordingly.

Nevertheless, in unity lies strength. For the People's Health Assembly to move forward toward transforming unfair and unhealthy social structures, especially at the global level, the solidarity that emerged at the PHA in Bangladesh must be sustained and reinforced. There needs to be continued active communication among participants, and a mechanism whereby groups in different parts of the world can be supportive of one another in times of crises.

It is critical to maintain adequate channels for information-sharing. The PHA website on the Internet is a good start. To optimise it, however, we need a team of responsible people to maintain up-to-date information and to coordinate input from the various NGOs, health movements, and activists involved. At the same time a strong effort is needed to link up and communicate with similar coalitions in other sectors, including the environmental sector and alternative (people-centred) economics.

It must be remembered, however, that only five percent of the world population has access to computers and the internet. If the PHA is to reach and involve a broader sector of the population – including those with the least voice in the decisions that affect their health and lives – more traditional means of communication are also needed. These include newsletters, radio, videos and street theatre, as well as community health workers, union organisers, and others who learn to be effective educators and agents of change.

For all this to happen – and for the movement behind the People's Health Assembly to stay alive – all of us involved must look for ways to contribute and to encourage others to contribute, each in our own way.

It will be an uphill battle, but the struggle is worth it. In the long run, it is a struggle for the life, health and survival of our species and our planet.

Organisational Lessons Learned from PHA2000

To follow is a tentative list of suggestions based on lessons from the People's Health Assembly that may be helpful in planning a follow-up event or other popular forums for change.

- **Keep the event democratic yet on track**

Seek a balance between guided facilitation and open-ended discussion. Clarify from the start (as a guided group process) the overall vision and objectives of the event. At the end of each day assess the progress made (and obstacles encountered). Allow time in plenary sessions for well-informed speakers/educators to provide clear but comprehensive overviews. (There needs to be A CLEAR ANALYTICAL, UNIFYING FRAMEWORK, presented and discussed in a plenary, that provides a foundation and overall direction for the event as a whole.) Prepare in advance guidelines for facilitators that will help them keep the process democratic yet on track. (Facilitate a participatory process that keeps discussion focused and makes steady progress toward the agreed upon vision and objectives.)

- **In preparation for the event**

Be sure analytic and steering committee members (and/or supporting staff) can devote enough time to adequately plan guidelines, facilitate prompt communications, and carefully review potential contributions/activities for the programme agenda. Be sure avenues of communication, e-mail addresses and websites are correct and functioning as well as possible, and that all correspondence is promptly answered. Seek input from participants (experiences, papers, stories) which are structured in an analytic, problem-solving way that can give a pragmatic direction to the conference. Screen stories and testimonies ahead of time. Give people suggestions for helping their presentation contribute to the thrust of the conference: i.e. linking local hardships to global events through a carefully analysed 'chain of causes.' Make an effort to invite key speakers and participants from all sectors that have been agreed upon to be included in the event (health, environment, alternative economics, education, labour unions, etc.). Be sure each sector is strongly and equally represented.

- **Improve communications**

Coach presenters to speak clearly and slowly, and to illustrate points with real-life examples and evidence. If overhead projections are used, make sure print is large enough to be easily read from the far corner of the room. Have a skilled communicator/educator give a clear, accurate

summary after each session. Look for effective ways to share the key points and conclusions of concurrent sessions at the plenary. (Focus on those points that will carry the conference theme forward.) Check if people understand what speakers are saying (in terms of both language and content), and look for ways to share ideas more effectively. Make arrangements for simultaneous translation, even if it means one bilingual person whispering into the ears of others.

- **Keep the process rational and constructive**

Encourage both speakers and participants to present fair, balanced, accurate information, and to criticise policies or institutions based on solid evidence and experience. Welcome thoughtful debate and discourage slogans, rhetoric, and offensive banter. When considering whether to invite a person from 'the opposition' (e.g. World Bank), sound out participants in advance – and take their suggestions into account. If a speaker from 'the opposition' has been invited to speak, listen to him courteously. Oppose his arguments with better arguments – not abusive language and tomatoes. Back up your arguments with solid evidence and hard-to-refute studies and facts.

- **Toward a way forward**

Plan for follow-up action when planning the event. Schedule plenty of time in the forum for discussion of 'the way forward.' In that discussion, have facilitators who can keep inputs relevant and down to earth. Identify groups and organisations like the Third World Network that are active in specific areas. Ask them to identify, lead and coordinate the area of their expertise as identified in the People's Health Charter. During the event, record if possible by tape all the plenary presentations, and the concurrent sessions. Have someone carefully edit this material and make the conference proceedings available in publications and on the web. Include instructive illustrations (verbal, pictorial) to liven it up.

- **After the event (follow-up and future action)**

Before the event, plan (and try to raise funding) for follow-up activities and action. Make sure adequate funding and personnel are available so that communications and coordination are smoothly maintained after the conference is over, and proposed activities continue and multiply. Make every effort to maintain full and clear communication with all participants. Be sure everyone (including those without e-mail) has a COMPLETE ADDRESS LIST (mailing addresses, telephone, fax, e-mail and website of all groups/participants). Develop and maintain various avenues of communication

– e-mail, website, printed newsletters and group correspondence – to keep participants informed and involved in action plans. Keep websites (complete with relevant LINKS) regularly updated. Encourage support and solidarity with all participants in the struggles of one another's groups, especially in crisis situations.

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健康：發展不能突破的底線

黃 平[1]

迪慶藏區，偏遠而令人著迷的地方。這裏山水草木，男女老少，都讓人相信人間確有無言的歌。90 年代以來，我經常在雲南的山區跑，但是到迪慶，還是最近兩年的事。本篇報告寫於兩次實地調查之際，其間經歷的人和事，看到的山和水，大多都被精簡掉了。

開篇

「以防治傳染性疾病爲主要任務的第一次衛生革命在農村遠未完成……」

「農村衛生、預防保健工作薄弱、醫療保障制度不健全、衛生投入不足、資源配置不夠合理……」[2]

如果不注明出處，嗅覺敏感的人可能又要認爲這不是海外反華勢力是在污蔑大好形勢，就是什麼人又在懷念過去、爲「專制辯護」了。

1999-2000 年，我和幾位研究人員來到雲南的迪慶藏區，我的工作是瞭解醫療衛生方面的情況，這題目也是我自己選定的。這 10 餘年來，我無意間介入了一些「貧困地區」的「發展專案」中，愈來愈感到人們的身心狀態（健康和教育只是標誌它們的重要方面）是比單一的現金收入水平更重要的尺度或「標準」。有的地方，已經出現了收入有所上升，但卻抵不上醫療和教育支出的情況，有的地方的健康和教育水平甚至隨著收入的上升而下降了。

退一步說，即使收入仍然是各地政府和老百姓共同關心的主要議題，也得清醒地看到，對很多山高路遠的中小社區來說，投資、招商、援助、貸款、救濟、慈善，常常都是可望不可及的事情，最多也就是杯水車薪，做做樣子罷了。在這後一種情形下，與其「豁出生存搞發展」（吳國盛語，見《讀書》，2000 某期），把水和空氣在內的環境搞壞、把人的身體搞垮、把居住環境搞得亂糟糟、家家都裝上防盜門，還不如慢點就慢點，少點就少點，但人際之間還有基本的信任感和安全感，人們還能就近上學和就醫、天還是藍的、水還是清的……

這些，無疑都太保守、太落後、太不合時宜，不是小農意識就是「計劃經濟」思想在作怪！

還是讓我們來看看從這次調查中瞭解到的情況吧。

觀察

一到雲南，就和省裏衛生系統的主要幹部座談了一天。他們的熱情和重視都在其次，最令我的難忘的，是他們幾乎是異口同聲地痛陳鄉村防疫保健醫療方面的種種難題，有人直言：「總不能搞得還不如'文革' 時期了吧！」

1、本文建立在如下觀察基礎之上：

（1） 50年來的雲南迪慶藏區社會，並沒有像西方發達社會那樣按部就班地沿著「現代化的經典路徑」有邏輯地遞進：人口急速向城鎮聚集並因而出現百萬人口以上的大城市，但與人的生活和健康密切相關的基礎設施和醫療服務等都跟不上人口的增長和聚集，結果是各種疾病增多了，特別是傳染病在人口聚居區（特別是在貧困人口聚居區）蔓延得很快，它們等奪去了許多人的生命，人們總體的平均壽命在一段時間內不是上升了，而是下降了。

（2） 相比較而言，本文所依據的實地調查表明：雲南藏區的城鎮化 50年來有所發展，但是還沒有在當地出現大中型城市，即使是縣城的[3]規模也沒有在改革以來的20年間內迅速膨脹、城區人口雖有所增加，但是還沒有急速聚集，同時，由於一些相對符合實際的政策和制度安排，雲南藏區的疾病控制和醫療服務水平 50年來有了很大提高，人們的身體健康和營養狀況有了很大改善。[4]

（3） 但是，由於地處偏遠-高寒地區，適合當地經濟 社會 文化的可持續發展機制是什麼還不甚清晰，種種誘人的發展「機遇」也很稀少，短期內擺脫「補貼財政」和「吃飯財政」，並進而推動社會保障事業、改善社區村民的醫療條件的可能性並不大。

（4） 更有甚者，隨著自上而下、自中心而邊緣的急速開發進程和普遍存在的追求短平快心態，不但諸如環境生態問題、社會整合（而不只是狹義的「穩定」）問題容易受到嚴重忽略，疾病控制和醫療服務也可能進一步弱化，部分地區和人群（尤其是偏遠地區的社區人群）中可能會出現經濟收入有所增加、健康狀況反而下降的情況，曾經在一定程度上受到有效控制的常見病、多發病反而又有可能蔓延開來。

2、因此，本文認爲，目前雲南藏區（以及其他許多偏遠貧困農村地區）的常見疾病控制和基本醫療服務問題，不可以簡單套用西方發展的「經典路徑」來解釋，即是說，並不是簡單的「工業化→城鎮化→人口聚居但醫療服務滯後→疾病蔓延，健康惡化」的過程。比較而言，本文更傾向於從以下角度來看待目前雲南藏區在疾病控制和醫療服務方面的問題：

（1）**從發展的格局上看**，作爲後發地區，雲南藏區如其他偏遠地區一樣，面臨著巨大的地區、部門、行業、城鄉、群體的不平衡，其既表現在機會、資源、路徑等方面，也表現在結果、受益方面。例如：該地區的經濟發展和社會事業都不僅明顯落後於沿海開發地區和內地的城市地帶，醫療服務和身體健康方面的改善也落後於邊遠地區自身經濟的增長和技術等方面的改進；目前的西部大開發，旨在改變東西部的地區差異，但東西地區差異的縮小或拉近並不一定意味著必然伴隨一個地區內城鄉差異/中心邊緣關係的改變，「西部大開發」並不必然會使類似雲南藏區這樣的偏遠地區很快直接受益，尤其是不會使偏遠地區的弱勢群體很快直接受益，而更多地是把前20年對東南沿海和大城市的傾斜開始向西部的省會城市和西部其他的大中城市轉移，更偏遠的山地和農牧區很有可能繼續處於不利的地位，甚至還有可能出現西部的大城市開始與東南沿海陸續「接軌」，卻把西部的偏遠地區甩到更邊緣的位置的局面。

（2）**從體制上說**，到現在爲止，可以說，還沒有成功摸索出各種適合中國偏遠地區具體情境的制度安排或政策框架，各偏遠山區和少數民族地區更多地是以沿海或大城市前一段的發展（或更準確地說，「大開發」）爲模式和榜樣，而在「模仿」和「追趕」的過程中，常常出現爲增長而增長、爲發展而發展的盲目開發或破壞性開發；在此過程中，愈是邊遠的地區，愈是急於追趕或仿效沿海和大城市的發展速度或模式，就愈要付出更高的環境成本、社會成本和健康成本；這些地區雖然並不會很快實現「現代化」（不論按照什麼「標準」），但是在疾病控制和醫療服務等方面確實面臨很大的挑戰，人們的健康狀況也有可能出現起伏或反覆，某些曾經得到控制的常見疾病和傳染性疾病在部分社區再度蔓延開來的可能性仍然存在。

在發展的思路上，由於新一輪發展勢頭很猛，在貧困地區又特別強調引資、招商、貸款、開發、旅遊，但是有可能忙於這些具體領域中的繁重而煩瑣的工作，忙於使各項工作達標以確保自己的「政績」，忙於應付名目繁多的檢查和視察，卻忽略發展的根本目的並不是各項指標的增長，並不是統計上年度人均收入或人均GDP

的增加，而是切實改善人們的生活質量，包括物質生活（財富量只是一個方面，舒適感是更重要的方面）和精神生活（文化活動類型、次數、設施也只是外在的指標，更具有意義的是安全感、信任感、社區成員間的認同程度和整合程度、身心健康狀況）的質量；在理論上，引資、招商、貸款、援助、慈善、旅遊、教育都不是不可能促進健康保健和提高醫療服務的水平，但是，由於後者在發展思路上是派生性的，其本身在各地的發展過程中並沒有體現出重要性，因此也有可能在實際的盲目開發/過度開發過程中帶來新的環境污染和疾病蔓延；由於開發和旅遊等急速推進，外來人口的急劇增加，各類餐飲、娛樂點站也急遽鋪開，防疫檢疫都會明顯滯後，從而有可能出現新老疾病交錯，舊病復發、新病難防的局面，其不只是器械、設備方面的問題，或醫療人員的數量或水平方面的問題，更是發展思路上的問題，在只要是外來的投資（特別是「外商的」投資）就必定有利於當地的發展的思路下，健康與疾病問題要麼可能被忽略，如健康教育就沒有被算作教育，更沒有被看作是發展的重要環節，要麼僅僅作爲附帶的或僅僅是爲發展服務的工具，如社會生活中的人被還原爲人口—勞動力，後者又僅僅被看作促進經濟增長的要素，人自身的健康和滿足感讓位於他們爲發展—增長貢獻了多少產值和利稅。

幾個命題

衛生與健康，關涉到人民的福祉。改革也好，發展也好，都是爲了提高人的生活質量，增進人的幸福感受。人的身心健康狀況，既是社會發展的重要指標，也是社會發展不能突破的底線。

本文基本的假設性命題是：

1、 相對適合偏遠山區具體情況的制度安排和發展思路，只能是在經過多年的實踐探索之後才可能逐步找到，而經過了 50 多年的實踐和曲折，包括 20 餘年的改革和發展，雲南藏區的各級幹部和群衆已經積累了相當豐富的經驗，已經有條件開始把經濟－社會－文化－生態的協調作爲新世紀制度創新的起點。[5]

2、 不論物質條件多麼困難，也必須從可持續的全面發展的角度來考慮雲南藏區（以及其他偏遠貧困地區）下一步的戰略，發展的思路也應該是多方位的、綜合的，雖然在任何一個特定時期內、一個特定地區中，會有所側重，有所捨棄；某一類單項切入（例如從教育入手，或從灌溉開始）也不是不可行的。

3、 大量的不同的研究都從各自的角度表明，先破壞（包括破壞人的身體健康）後修復，先污染（包括使人的身心受污染）後治理，不僅經濟成本更高，而且極有可能會導致人們生活質量的下降和社會關係的解組。

4、 基本醫療防疫保健，帶有福利和保障的性質，是政府必須要承擔的責任，而不是要往商業化方向發展的產業。在偏遠貧困山區，即使進行社會保障制度方面的改革，也要著力於社會保障，而不是商業性保險。這是再造農村合作醫療制度時必須注意的關鍵環節。

5、 雲南藏區基層的的衛生工作，在當前和今後一個時期內，主要是如何確保鄉村的醫療、防疫、保健在現有基礎上完善，常見病、多發病如何得到基本控制，醫療服務如何更深入、更持久。而爲了這個目標，除了硬體方面的基礎建設（醫院建房，購置設備）外，更重要的是對鄉村醫務人員的制度保障和多種形式的業務培訓，對鄉村社區成員的健康教育和提供必須的防疫免疫和必要的醫療保健。

迪慶醫療衛生現狀

（一）、全省衛生事業狀況

雲南省 50 年代初期以來醫療衛生事業有了很大改變。（見表一）人均壽命從 50 年代的 35 歲提高到 1995 年的 66.4 歲。

表一：雲南衛生事業變化情況。

	醫療機構	醫務人員	床位	傳染病發病率*	孕婦產死亡率*	嬰兒死亡率
50 年代初期	96	991	615	4109	1500	30%
1999 年年底	11875	148429	97197	207	101	3.7%

*：每 10 萬人中的個案數。

資料來源：《雲南衛生工作簡報》，2000 年 8 月 31 日，昆明。

（二）、迪慶衛生事業狀況

1、迪慶州

根據省衛生部門的資料，全州到 1999 年底已有各級衛生機構 70 個，其中 28 個是鄉鎮衛生院；全州 182 個行政村中有 174 個有村衛生室（靠近鄉鎮的村不設衛生室），鄉村醫生 227 人，衛生員 478 人，農村接生員 365 人。

2、中甸縣

1911 年到 1949 年 38 年中，中甸的死亡率很高，人口年均僅增加 0.56%。1960 年代以後，死亡率下降很快，1965 年 1.3%，1970 年 1.0%，1980 年 0.8%，1990 年 0.64%。1990 年，因病死亡的佔 20%-35%，嬰兒死亡佔 10%-15%。死亡率從 1959 年的 1.549%降低到 1990 年的 0.646%。中甸的人均預期壽命 1990 年達到 62.8 歲。（《中甸縣誌》，昆明：雲南民族出版社，1997 年，第 120 至 142 頁。）到 1999 年，中甸的嬰兒死亡率降低到 0.3695%，孕產婦死亡率從 1990 年的 0.307%降低到 1999 年的 0.123%。（《中甸衛生工作情況》，雲南中甸，2000 年 9 月，第 9 頁。）

3、德欽縣

1951 年全縣只有一個醫院，5 名醫務人員。到 1998 年，已經有衛生技術人員 220 人，鄉級衛生院達到 6 個（129 名醫務人員），41 個行政村全都有村衛生室（67 人），村民小組另有衛生員（137 人）和接生員（78 人）。全縣每千人擁有衛生技術人員 3、79 人。（《德欽縣概況》，昆明：德欽縣誌辦，2000，第 30，80 頁。）

4、幾個重要因素

雲南藏區在醫療衛生方面的取得的成就，固然與當地社會經濟的發展有密切的關係，但是，雲南各級政府所做的各種比較適合當地情況的制度安排，是不可忽視的重要因素。這些安排包括：

（1） 雲南藏區從 1990 年以來在所有行政村普遍建立或恢復了村衛生所，配備了鄉村醫生，並由縣財政和縣衛生部門解決其工資待遇，由各縣回銷糧中解決其口糧，由村公所提供村衛生所的房屋和鄉村醫生的住房，目前全州村衛生室達到 100%；

（2） 雲南藏區的醫療與防疫、保健沒有從體制上截然分開，在每個鄉鎮的醫院都建立了預防與保健組，落實了專職的防保人員，做了大量疾病預防和婦幼保健工作，鞏固了預防和免疫成果，農村初保和婦幼衛生保健工作組織落實較好，1999 年年底計免四苗覆蓋率保持在 90%以上；

（3） 雲南藏區存在著藏醫的傳統，近年在藏醫、中醫和西醫結合方面做了許多努力，培養和培訓了一批藏醫和中醫，緩解了西醫人員、器材和藥物不夠所造成的緊張。

訪談個案一：前赤腳醫生（男，藏族）

我不是本村人，結婚過來的。15 歲大串連還從家裏走到縣城，再到昆明，到上海，最後到了北京，參加過毛主席第七次接見。

我原來是跟一個江湖醫生學的，1988 年又進修了 2 年，在村公所行醫，

一共 18 年，95 年下放到村。原來當赤腳醫生每月有 25 元，1995 年就沒有了，算是退休，給了 1000 元退休費。

現在村裏還有個鄉村醫生，98 年從縣衛校畢業來的，每月有 120 元。但是 80%的人還是來我這裏看病，那一個剛畢業，經驗少。不是吹牛，我的技術要高些。當然，我要看不了就去縣醫院，再不行到州醫院。前幾天就有個小夥子從山上撞下來，揀菌子從高山上滑下，肋骨斷了。

來找我的比較多的是感冒，拉肚子，胃痛，黃膽。我也管接生，用新法接，一會兒就要去給一個產婦打針。我學過，89 年縣衛生局辦了一個月的培訓。老百姓歡迎新法接生，以前因爲沒有醫生才用老法，有死亡的，現在都用新法了，搞得我很忙，有時候一夜搞到天亮。全村 300 多人，一年有 5-10 個嬰兒出生。沒有超生的，也沒有重男輕女的，女兒男兒都是自己身上的一塊肉。超生要罰款，這裏的老百姓遵紀守法，也信活佛，我們村就有一個活佛，他也開車搞副業，不知道他究竟是不是活佛？老百姓生病不找他，但臨死時要找活佛給指路。

現在人的身體比以前好了，吃得好了，以前靠工分，多勞多得。現在看病的人多了，錢有一點，主要是揀菌子，打工，給人沖牆，砍木料，現在也不砍了，那是神山呀。當然，如果的造房子還是要砍。

看個病開個藥一個月可以有 150 到 300 元，一年有 2000 吧。但也有欠錢的，2 年 3 年才還。賴掉的少。他不交藥費我也沒有辦法，人道主義、社會主義嘛，醫生也難做，這樣病那樣病，你不看也不行。世界上的事情說不清楚，各有各的打算。

我也種種地，6 口人 5 畝地，還種核桃，用來榨油，換米。我們分地是全縣最早的，搞試點。現在主要靠給遊人牽馬，牽馬收入比看病高一點，平均 15 天有 2 次，每次 78 元。

我是外來人，連煙也不敢抽，好不容易存了 5000 元，被一個親戚偷了，就是剛才路上給你吃仙人果的那個人，我現在都不給他說話了。就一個村裏，都知道是他偷的，我找來了公安局也沒有用，後來就去山上求拜，咒他，咒了幾次，他哥哥就死了，後來再去咒，他母親也死了，都活不長。

現在鄉村醫療最重要的是要解決衛生習慣問題。老百姓不講衛生，說不通。現在是你不求我我不求你的時代到了，分田以後就各顧各，鬧矛盾，一點小事就鬧。我讓他們講衛生，他們還以爲我在賺錢。我連挂號費也不收。有些人不洗碗，一年也不洗，不警覺，不懂講究衛生哪能減少疾病。風濕多，鞋濕了還繼續穿。

第二重要的是藥。現在的藥假的多，沒有效。老百姓吃西藥，相當貴，藏藥也不便宜，同樣是感冒，吃西藥便宜些。因爲藏藥要從西藏買過來，以前我還可以自己採藏藥，現在我人老了，51 歲了，爬不動雪山了。

調查中的一些發現

改革開放以來，尤其是 1990 年以後，醫療衛生事業有了很大改進，縣裏自辦或委託州辦鄉村醫生職業高中，培養了幾百名鄉村醫生。現在，農村三級醫療預防－保健網路現已基本形成。這在我國偏遠少數民族地區中（特別是藏族地區中）是了不起的成就，是雲南各級政府和藏區的幹部群衆共同努力的結果。

難題

但是，必須看到，迪慶州文化教育水平和基礎設施相對滯後，經濟社會發展的起點較低。特別是其地處高寒山區，交通極不方便，雖然按照每千人計算的醫務人員較多，但實際上平均每個醫務人員所覆蓋的地區太廣，太陡。尤其是一些偏遠的村落，村民的物質生活水平很底，衛生意識也很差，衛生事業發展非常緩慢。許多人還處在小病不用看、大病看不起的狀態下。所謂「小病不用看」，並非以爲它們可以自己慢慢好起來，而是或不願意付錢/付不起錢，或是村衛生室、鄉衛生院路途太遠；而「大病看不起」不只是因爲縣醫院才有能力看大病，而那就更遠，更是因爲治療大病更昂貴。於是常常出現這樣的情況，病人一直要拖到實在不行了，再匆忙被擡到縣醫院，搶救不僅要花掉更大一筆錢，而且也不一定能遷就過來，最後還使得家人欠下一大筆債務。結果往往是小病拖成大病，「因貧致病，因病返貧」的惡性循環現象還比較突出。本次入戶調查資料也顯示，社區中的農—牧戶，要麼沒有醫療開支，要麼醫療開支就特別高，比全國農村的平均醫療開銷要高得多！[7]

訪談個案二：某鄉村醫生（男，藏族）

先說村裏的大概情況吧。這個村全村有 350 多戶，分爲 15 個村民小組，2000 多人。生活主要靠農牧業，96 年開始搞旅遊，到 2000 年有 9 個小組的人參加了。說是旅遊，也就兩件事：一是佈置自家的花園讓旅遊者拍照，二是給遊客牽馬。收入上有很大提高，96 年以前人均也就 400 來元，這幾年有 500 600 了。當然，差距也大，多的一家有 4 5 萬，少的只 1 2 千（五保戶不算在內）。

我本人編制上屬於鎮的衛生員，到村裏來「蹲點」三年了，原來在州衛校畢業，又到拉薩實習過一年。州衛校和拉薩都是學的藏醫，1994 年一起考上的，一共有 40 人，每縣各 20，就是學藏醫。現在工作是中西藏結合（笑）。

村裏來看腸胃病的比較多，胃病、潰瘍、12 指腸都有。風濕也多，但風濕都去州的藏醫院去看，藏藥比較有效，但也難治癒。30 歲以上的也有高血壓，另外這裏氣候幹，風大，打青稞灰塵也大，沙眼多。去年還有一次痢疾，小學裏 9 12 歲的學生都染上了，70 80 人吧，我到學校去給治的，一個星期下來才治好。

產婦一般在家裏分娩，這幾年住院的多起來了，主要是離醫院近的來，（不來的除了遠）觀念上也保守。婦科病太多，她們去縣醫院，個人衛生上覺得不

好意思，習慣上也有問題，不洗手。供水沒有問題，但是多數沒有廁所，有也不衛生。婦女主任受過點教育，知道洗手等。不過我來了三年，還沒有產婦死亡的，去年嬰兒死亡有兩例，但不是生產的時候，一個是肺炎，還有一個不清楚。

我主要給病人開西藥，我給院長提過藏藥，院長沒有同意，（因爲）沒有資金買設備，一套需要7 8千。一般藥品是夠的，有些藥沒有，我就開單子，病人自己去鎮醫院拿。我也做縫合、打針、輸液、包紮。

現在一天平均有三—四個人來看病，一般兩天中就有一個人要送到州醫院去。感冒的時候也來看，光吃藥十幾元就夠了，輸液就要20多。有些人看了病沒有錢，先欠著，去年就欠了500多，年底都補上了，藏族人都比較守信用，當然去年我還是墊了40-50元。今年3月以來還有300多沒有付。村民看病吃藥是一筆比較大的開支，有些也就不看病了，40%多吧，先拖著，到了不行了再來看，已經是晚期了。

傳統上病人要先去找寺廟算一算要不要看病（再決定來不來找醫院），現在也有先去寺廟的，愈來愈少了。

總的衛生條件太差，沒有達到2000年人人享有醫療保健的標準，飲食上不衛生，習慣上，80%的男人要抽煙喝酒，近年婦女抽鼻煙發展很快。

全村僅我一名醫務人員，最遠的自然村有20多公里，有些農民生了病，叫我出診，而一旦出診，其他病人又找不到我，印象又不好了，來回一耽誤，再輸個液，半天就過去了。

我過去的收入是領工資，鎮醫院發50%，鎮政府發50%，賣藥的收入一個月300多都上繳。99年5月以後鎮政府只發30%了，剩下的20%要自己從賣藥的收入裏提取，按5%提，如一個月能銷1500-2000元，就可以補上那20%。所以說，工資說是1050一個月，扣除了20%，只有800元。

對了，我還要給0 5歲的娃兒搞疫苗接種。防疫接種明顯提高了兒童的健康，出麻疹的3年來沒有見過，過去幾乎人人都要出，有的家長還認爲孩子都要出麻疹。經過鎮、村、社裏做工作，都注射了。防疫本來不是我的分內工作，去年95%接種，達到標準了，今年我打算告訴鎮醫院不幹了，太費事，幾乎每周要跑，又沒有交通工具，一次就要10天才能打完，這樣20%的門診收入就沒有了。

另外一個比較值得注意的現象是，傳染病及其他一些疾病發病率有上升的趨勢。這既包括痢疾、肝炎，也包括結核、性病。有的村幾乎人人咳嗽帶血，鄉縣幹部望而卻步。有的縣的負責衛生的主要幹部也染上了傳染病。當然，這裏有許多具體原因，例如：痢疾、肝炎、紅眼病及皮膚病比較多地發生在寄宿學校或其他人口較密集的地方，飲食和器具習慣也是觸發其流行的重要因素，其中痢疾發病率到夏天特別高，紅眼病、一般皮膚病則沒有在統計之列；結核則與當地奶製

品的製作和保存方式有關；痲瘋是因爲 1984 年以後改變了原來的集中居住治療辦法；而性病（梅毒、淋病）在 1950 年以前沒有普查過，1952 年以後開始進行免費治療，到 1964 年已基本滅絕，1990 年以後再度出現，這跟旅遊業的興起而基礎設施跟不上、觀念－制度上的漏洞都有關係。（參見《中甸縣誌》，昆明：雲南民族出版社，1997。）

值得注意的是，有些傳染病過去控制得比較好，現在不能因爲搞生活而使它們再度蔓延，或者，應驗所謂「財神跟著瘟神走」：即是說，許多時候不到疾病蔓延就沒有財力上的投入，而由於基層要完成各種衛生、防疫和保健方面的指標，常常出現漏報或虛報現象，待到發現一旦真有了疫情就可能有上面的專款投入時，又有反過來誇大疫情的時候。

1、 新的改革勢頭給當地帶來的顧慮

改革給雲南藏區的醫療事業帶來了發展的機遇。用人制度和行醫方式都比過去活了。有些定向培養的中專畢業生與用人單位實行了簽約，例如到村衛生室工作若干年；也有的醫院把門診開到了臨街的地方，既方便了病人也增加了門診收入。

1）財政政策要求與實際困難之間的差距較大

90 年代後期以來，雲南藏區的各縣鄉的醫療單位都被財政上要求進行差額預算，各個醫療單位（實際上落實到每個個人）要自找工資 10%-30%（各縣有差異），事實上改變了原來貧困地區實行福利型醫療衛生保健的做法。醫務人員開始對病人做不必要的檢查，開不必要的處方，增加了病人的負擔。許多村民小病不看，就是因爲看病愈來愈貴。

而且，這樣的安排導致了醫務人員在基層的聲譽下降，很多病人及其家屬認爲醫務人員是賺錢爲主治病爲次。本次被調查/訪問的許多醫務人員和機構並不願意看著本來就經濟困難的病人再多交錢，更不願意被看作是「賺錢專業戶」，就仍然按照原來的價格收取掛號費和門診費，結果是，幾年下來，醫務人員自己的工資大都降低了 10%-30%。

從全省的角度來看，建國初期國家對少數民族地區的醫療費用是實行免減的，現在隨著財政切塊包乾，國家的投入減少了，醫務人員提供的醫療服務面變窄了，普通人看病變得難了。

訪談個案三：某村孩子（女，藏族）

我 17 歲了，讀過四年小學，15 歲回來幹活。有一個妹妹在上 6 年級，一個姐姐在幹活，爸爸也在幹活。家裏共有 8 個人。家裏種糧食，養牛 5 隻、綿羊 5 隻，有 3 隻馬，經費從給遊客牽馬來，男男女女都去牽，兩匹馬來回一趟 100 元，一個月 2 3 次，有 2 3 百。去年好，今年不行了。我們也採菌子、松茸。30%左右靠松茸。伐木不允許了。父親說 97 年以前伐木佔到收入的 80%，現在有指標，也有幹部伐木的，我們不敢。總收入減少了。連牽馬也不行，全村 90 多家，每家 2 匹馬。

去年以來我肚子痛，到縣醫院去輸液 10 幾天，也不知道是什麼病。爸爸說去年我看病花了一千多。媽媽去年得膽囊炎在州醫院住 10 來天也花了 1500 多。感冒在村裏醫生就可以看，要花 10 來元錢看一次，一般都拖著。感冒主要看季節，採松茸、牽馬的時候就不看。爸爸有風濕，7-8 年了，經常要吃藥，到處去尋醫，中、藏、西醫，轉著看。錢不夠就找人借。奶奶得過白內障，動過手術，那是很多年前的事了。

村醫生來以前我們到縣醫院去看病，不算感冒和腰酸背痛，差不多 10 個人中有一個人得病，風濕，高血壓，腎結石，腸梗阻，等。現在醫院看病費用高，也不能根治。看村醫有 9 公里，我們搭車去。也吃藏藥，別人送的，不花錢，西藥當然更有效，看村醫比較便宜。最花錢的還是吃藥，第二是上學。

藏藥以前沒有發揮多少作用，缺乏瞭解。最近的喇嘛寺有 20 多公里。

2）很難吸引和留住醫務方面的人才

現在，隨著經濟和人才市場搞活，藏區很難吸引和留住醫療方面的人才，不僅的當地人才往外跑、外地人才不願來，而且，由於縣財政困難，醫療衛生方面即使只是中專畢業生，也分不出去或分不下去。

目前，關於縣級機構精簡的精神已經傳下去了，許多本已簽約到鄉醫院/村醫務室工作若干年的中專畢業生擔心自己要被首先精簡掉，開始動心另謀他途，這也致使縣州醫療部門和政府不得不擔心醫療隊伍會受到衝擊，擔心已經初步建立起來的三級醫療一預防一保健網路如何才能鞏固和提高。按照州衛生局文件的說法，「村級衛生組織的鞏固工作直接影響著初級衛生保健工作的正常展開」。

在雲南藏區，特別是一些偏遠的鄉村，目前還處在缺醫少藥的狀態，對傳染病多發病的控制力度較弱，醫療服務水平很低，鄉村醫生的待遇本來就很低，一旦要精簡鄉村兩級的醫務人員，就會使病人看病更遠更難也更貴。

3）醫務人員的業務培訓機會更少了

過去雲南藏區是比較注重醫務人員的業務培訓的，這既與當地人員的業務水平較低有關，也與當地的制度安排使各級醫院和醫務室有一定能力派人出去學習

有關，與上級醫療部門能夠安排各種培訓和進修有關。州政府過去一直鼓勵醫務人員就讀該一級的醫學院校，或赴外進修、請人來培訓，而參加過進修或培訓的醫務人員一般都反映收穫較大。現在，由於財政狀況和財政制度的變化，由省、州提供無償或低收費培訓的可能性反而降低了，北京、上海、昆明等地的醫療機構派人來幫助培訓的機會也減少了。

訪談個案四：某鄉村醫生（女，納西族）

我在州衛校學了四年，97 年畢業後分配在鎮醫院工作了半年，98 年派到這個村來，簽了 20 年合同。去年這裏還有個藏醫，現在回到鎮上去了。再早還有個村醫（赤腳醫生），95 年鄉政府一次性補償，就回去當農民了。

我這裏一般每天有 10 來個人來就診，主要是感冒，腹瀉，頭痛，咳嗽，差不多一半都要輸液，根據病情決定，也有的病人要求輸液。他們一般剛剛發病不來看，只要還能吃飯走路就不來。拖幾天才來，就得輸液。傳染病主要是痢疾多。衛生意識不行，鬧肚子後以爲是食物有問題，其實常常是沒有注意飯前洗手，有的人家不洗碗，一年也不洗一回。個別的也有得結核、肝炎，但是沒有檢查手段，不知道是不是傳染病。

老百姓得病後也有去喇嘛寺的，還比較多，找喇嘛、尼姑，念經或者到外面去轉經，寺裏也有個藏醫。

一個人一般一年下來要看病 3-4 次，小病 10 來元，重一點 60-70 元。還有些人乾脆就不看，重一點的就去鎮醫院，或者直接去縣州的醫院。這幾天農忙，有病也不來看。

幾年來老百姓健康知識多了些，以前打防疫針很費力，他們對衛生保健不以爲然，這幾年通過宣傳都接受打防疫針了。我每兩個月下鄉一次，打防疫針，做體格檢查。由於防疫搞好了，得病的人少了，來看病的人少了，醫院的收入也就少了。

三年來孕產婦沒有死亡的，97 年嬰兒死亡多一點，主要是腹瀉。98 年有 5 個嬰兒死於肺炎，99 年 3 個，99 年還有 3 人是接生窒息的，98 年一個。村裏用新法接生的太少，每 10 人中有 2 人。（見表二）

我覺得知識不夠用，幾年來只有 99 年培訓了一次，是關於防疫保健方面的，一共 3 天，縣政府組織的，收穫很大，原來在學校沒有學過防疫保健，現在比較熟了。但是我不會拔牙和縫合，沒有訓練過。很多事不會處理。一年能培訓一次就好了。

現在是農忙，就我在村裏值班。治安比較好，沒有感到有什麼害怕。但是一個人行醫有點難。白天黑夜，有兩個人就好商量。現在事情太多，忙不過來，待遇也不行，想吃吃不上，想買買不起。聽說以後還要精簡。

表二：某村孕產婦與嬰幼兒存活情況

	接生	新法	住院	活產	0-28 天死亡	0-3 歲死亡	0-4 歲死亡
1995	37	12	0	37	1	2	2
1996	50	20	3	50	0	3	4
1997	43	22	5	43	0	1	1
1998	54	23	9	54	1	5	6
1999	69	12	12	69	3	1	4

資料來源：2000 年 9 月 6 日訪談個案三鄉村醫生

4）從以藥養醫到醫藥分開，給鄉村醫療機構造成新的壓力

他們擔心，這實際上是給藥業和藥販帶來了牟利的機會，最後還是把負擔加在了病人身上，醫務人員自己不僅得不到什麼好處，反而還會有損聲譽，病人的就診率也會在實際上降低。雖然有的縣採取了限制藥商藥販的措施（實際上是一種被迫搞的地方保護），但是前述 10%-30%的差額並沒有因此補上。以藥養醫的時候，病人對醫務人員的抱怨比較多，但是醫生還大都知道用藥的界限和病人的承受能力。醫藥分開後，如果藥業進入市場，邊遠地區又沒有多大力度打擊假冒偽劣，病人自己更難辨別真偽，鄉村醫務人員自身也不再考慮如何用藥的問題，他們給人治病的積極性反而有可能降低。

訪談個案五：某鄉醫院副院長，醫生（女，藏族）

我原來在縣衛生局，來這裏有 10 多年了，因爲我愛人有病，就回來了。我們醫院 1956 年就建了，那個時候聽說只有 3 個人，借的老百姓的房子。現在人多了，有 31 人，衛生人員 26 人，也沒有嚴格的醫生/護士之分，但內、外、婦產科都有，也有個計生處。常見病可以治療。下面的 5 個行政村也都有衛生室，有 7 個鄉村醫生，他們一個月只有 120 元，待遇太低，他們都是衛校畢業的，衛生局出錢培養了三年，但不包分配，哪裡來哪裡去。

現在一天有 30 到 40 人來看病，最多的是外傷，第二是小兒的肺炎、腹瀉，另外結核病發病率較高，住院的不多，一般在家裏。肝炎很少來看，除非有明顯症狀，才推到州縣的醫院去。

再就是計生的多。現在新法接生佔 50%，只生兩個，比較珍貴嘛。嬰兒死於肺炎、痢疾等，而不是因爲接生。

老百姓看病主要是交通不便，要走好幾天，最近也要走一天，最遠的要走 4 天。最大障礙是交通。

第二是費用高，我們只能開老百姓付得起的藥，一般有病得不到治療，搶過來已經不行了。幾乎都是白費呀。農村人口每人每年免 5 角，現在有一個村在搞合作醫療試點，每人交 2 元，鄉里出 2 元，縣裏出 1 元。解決不了什麼問題。

宗教信仰也是個問題，老百姓先去找活佛，問清楚是否要看醫生，看西醫還是看中醫。活佛的說法是，不能打針，金屬的東西不能接觸人體，本來已經不行了，醫生再打針，又沒有治好，活佛就更有理由了。很多時候我們去出診卻不讓打針。

再有條件也差，醫生素質也差。我們每年派一二個人去縣、州、省學習，由我們醫院自己出錢。過去出去讀書，省、州、縣各出 20%，現在沒有了。技術服務差，發展不快，剖腹生產就要轉到州醫院去（縣醫院更遠，要翻雪山）。醫務人員現在要自籌工資的 10%，壓力大，我們只好要病人先繳押金，不繳就不給治。但是這裏地廣人稀，來的人少，來了也沒有多少錢。今年還不如去年。老百姓主要靠松茸，今年才 120 元一公斤，比前年差幾百和千元。所以 10%很難解決。

現在也不敢要人，只能送現有人員出去進修。進修效果好，前年一伙人去昆明 6 個月，回來很受歡迎。6 個月就很有用，麻醉、拔牙、X 光，6 個月就行。以後派人出去就困難了，不可能派人出去學習了，只能短期開個會就不錯。

藏醫受歡迎，但比起西醫來還是少數。老百姓過去對中醫不大理解，最近幾年愈來愈受歡迎，服藥後見效呀。

我們一年有三次下去，冬天封山不能去，其他一個季度一次，一次一周左右。送疫苗，或自己去搞疫苗注射。上面每年定指標，防疫婦幼保健，都有指標，與我們定合同，年底交叉檢查、驗收。計劃生育超生的不多，藏族生兒生女都一樣。也有生一個的。

其實醫療比教育還困難，教育層層重視，工資有保障，師範畢業全部分配。衛校畢業就不管。當然教育上人員缺，醫療上編制滿了。但實際上很需要，比例好像不低了，但每人承擔的地域太大，我們不敢下鄉，四五個人下去看一兩個病人，不如不走，還可以節約補助。去年一個人下去 15 天，回來只收到 15 元，加上補助，他自己吃飯，住宿也難，還不如老百姓來。考慮到社會效益當然應該下去送醫送藥。現在醫院靠老百姓看病繳費，老百姓收入低又看不起病，所以很難。住院標準收 5 元，我們只收 3 元。掛號也是，高職收 1 元，中職 6 角，低職 3 角，搞了幾個月就搞不下去，只好恢復收 3 角。收費標準低，政策上可以提高，但老百姓窮，我們沒有辦法提高。藥也是一樣，新藥好藥用不上，不敢用。有錢人想用，我們要考慮大多數，有錢人也就 1%到 2%，最多 3%。

我要退休了，30 年工齡，可以領 100%。我們這裏年輕人多，他們業務上不錯，也沒有要求調走。就是房子太差，我這個房子 64 年蓋的，只有這一間，家用電器也沒有，來了人不好意思領到家裏。醫院地盤不小，就是沒有錢，光是解決 10%的工資就很難了。

初步分析

制度選擇

在雲南藏區，1950 年以後建立的一系列制度，爲後來的經濟和社會事業發展設定了一套路徑，其中對於衛生醫療，基本上按照福利原則安排的。雖然從衛生機構和人員數、人均預期壽命、疾病發病率、孕産婦和嬰幼兒死亡率等來看，雲南藏區原來的基礎很差，但是在新的體制下，經過半個世紀的努力、嘗試、摸索和曲折，現在已經初步具備了制度性條件，使社區一般成員在脫貧過程中開始享受醫療防疫保健網帶來的好處，許多疾病得到了控制。

改革以後，主要是通過放權和體制的調整，以及根據當地的歷史和現實情況（偏遠、山高、貧困、少數民族）所做的具體考慮，醫療、保健和防疫事業在雲南藏區有了長足的發展。其中比較令人注目的特色有兩個：（一）鄉醫常年住在村裏爲村民提供基本衛生服務，但不給村民增加負擔，而由鄉政府和鄉醫院承擔其工資或勞務待遇；（二）雲南藏區基層沒有從體制上把醫療、防疫和保健截然分開，同時還愈來愈重視藏醫、中醫和西醫的結合，注重爲當地培養和培訓村醫，並開始探尋再造農村合作醫療的路子。

從 90 年代後期開始，醫療系統的從業人員的工資不再是財政上的全額撥款，現在改革更進入了精簡縣鄉機構的階段，醫療系統開始準備要醫藥分開。在這種情況下，原有的優勢如何發揮，原來的基礎如何鞏固，都成了新的難題。現在，赤腳醫生從體制上已經不存在了，他們要麼回家務農/牧去了，要麼成了私營診所的從業人員/自雇人員。如果鄉醫（特別是駐紮在村子裏的鄉村醫生）的待遇和編制出現大的變化，勢必影響到整個基層社區的醫療、防疫、保健網路。簡單指望帶有太濃商業色彩的醫療保險，或靠村民自己出錢辦合作醫療，在偏遠的少數民族山區是很不現實的：要麼保險或合作金額太少而解決不了什麼問題，要麼給農牧區群衆再增加一塊負擔，實際上他們也還是負擔不起。[8]

這裏的問題在於，基本衛生（醫療、防疫、保健）不能當作一種靠時常運作的産業，也不能指望都單靠合作醫療或商業保險；基本醫療和防疫、保健作爲公共産品，至少在偏遠貧困地區，主要還是社會福利性和社會保障性的。

目前在吃飯問題得到基本解決的情況下，當地各級政府開始考慮以旅遊爲龍頭，帶動農牧業和其他行業。這在當地是經過多年思考和實踐後做出的選擇。需要注意的問題是，旅遊業並不必然就會（更不馬上就會）導致衛生條件的改善，反而還有可能出現新的疫情和病原（HIV 只是一例），例如餐飲業和旅館業快速發展起來，但是其衛生條件既不盡如人意也不符合衛生檢疫標準，再例如黃、賭、毒的出現，在這兩種情況下都會帶來健康和疾病方面的嚴重後果。

社會發展指標

如果按照 UNDP 的有關社會指標，如人均壽命、人均識字率，目前雲南藏區的社會事業發展在整個藏區中是比較高的，但比起其他地區來就並不算高。但是如果把人際之間的信任感、社區中的安全感、社會的互助和支援系統的有效性等也都考慮在內，雲南藏區又有很好的社會發展基礎，這是其他許多地區所不及的。還應該看到，雲南藏區人的素質並不低，尤其是他們沒有嚴重的性別歧視，在生育上也不重男輕女，這本身是很重要的社會資源。

現在雲南藏區的總體發展勢頭給人留下很深印象，從州到縣、從縣到鎮、上上下下都有一股勁頭，要在 21 世紀前期有所爲。同時，外界對雲南藏區也開始有了特別的關注。「藏區」本身就是一個熱點，「香格里拉旅遊」又是一個新的熱點。但是，這裏也與其他藏區或少數民族地區一樣，面臨著如何處理好一系列關係的問題，如：經濟增長與社會失範的關係、短期經濟效果與長遠社會利益的關係、本地發展與周邊地區的開發和破壞的關係、外來經濟文化標準與本地傳統宗教的關係，等等。這些關係，主要涉及到新的利益關係格局的調整，而不只是認識上觀念上的跟得上跟不上的問題。

特別重要的是，既要把握趨勢、潮流，更要考慮多數人在這個過程中受益與否、受益多少。而所謂「受益」，一個很重要但常常被忽視的內涵，是指人們在身心健康上的狀態和有疾病的時候所獲得的醫療服務水平。

雲南藏區的文化中有景仰自然、崇尚美德的傳統，即使是在高寒山區，他們也把生活理解得比活命和掙錢要豐富得多。藏傳佛教和民間宗教都有與自然及生靈和睦相處或拜之爲神的傳統，藏醫也在民間流傳至今。1980 年代以後，雲南藏區建立了自己的藏醫院，這些年陸續定向培養了許多藏醫。民間也有轉經/轉山的風俗，除了有信仰因素外，客觀上既是一種鍛煉（包括轉山中的天然藥浴），也是某種心理調節。

必須看到，由於種種歷史的、經濟的和文化的原因，有些疾病也與雲南藏區的生活方式有關係。結核菌在奶製品中滋生和殘留只是一個例子。控制和治療常見的疾病（包括腸道傳染病），既與如何提高經濟水平和生活質量有關，也與如何改變某些傳統生活方式/觀念相關。這些年在推廣疫苗接種方面雲南藏區做了很多有益的推廣，新法接生方面也在逐漸改變人們的觀念和習慣。但是諸如婦科疾病、嬰兒腸道、呼吸道和皮膚疾病等，很多與此有關的習慣仍有待調適或改變。

幾個方面的設想

雲南藏區發展到今天，已經有了一批既有管理能力也懂當地實際的人才，但醫療防疫保健方面，至今沒有一項適合偏遠少數民族地區的醫療衛生政策出臺，而是按照統一的指標去衡量和驗收，而在實踐中，由於指標太多，反而流於形式。

特別是，這些指標很多是從外在角度去衡量的（例如人均醫生或床位擁有量），即使是考慮到生活質量，也只衡量死亡率（如人均壽命或孕產婦及嬰幼兒死亡率），對日常生活中的病痛衡量少。

但是，這樣的問題不是雲南藏區自己能夠解決的，省裏也只能在全省範圍內做文章，如果能夠把偏遠少數民族地區的衛生健康事業再做通盤考慮，就有希望改變「一刀切」的現象。現在，雲南已經決定在邊境鄉村免去學生的全部學雜費，基礎醫療保健方面如能有比較大的制度調整，也會有利於提高當地民衆的生活質量和健康水平。

本文主張，社區成員的基本醫療、防疫和保健，應做到在鄉村兩級的衛生院和醫療點解決，爲了做到這一點，就要考慮：

在體制上，繼續堅持在制度上把基層社區的醫療、防疫和保健工作作爲一個整體來安排，防止出現重醫輕防、重藥輕醫的趨勢，不搞以藥養醫、醫藥分開；合作醫療試點，要考慮藏區的實際情況，如何結合藏、中、西，調動政府、集體、個人幾方面的資源，而不是簡單地朝著「老百姓出資搞保險」的方向走。

在財政政策方面，從省財政全額保證偏遠鄉村的醫療系統的業務人員的工資和福利費，減緩縣鄉兩級財政的負擔，同時也不要基層醫療防疫人員自己搞「創收」，不在鄉醫療系統搞「財政包乾，節餘歸己」，在村醫療點上，常用藥品對邊疆地區和偏遠山區的病人實行減免，其他地區和人群可以搞政府或非政府醫療救濟基金；上級財政對基層衛生事業的專項投入、房屋建設和設備購置在其次，更主要的是加強農村防疫保健系統的鞏固和完善，以及改水改廁、健康教育，後者要與基層教育系統合作，把以行爲改變爲主導、生動圖片爲形式的健康教育作爲農牧區小學衛生－健康課的基本內容和農—牧區健康教育的主要形式。

從業務方面說，加強對鄉村衛生（醫療防疫和保健）人員的經常性、實質性培訓，培訓的地點也可以在現場，而不必每次都要他們到縣、地、省裏的「培訓中心」去；繼續在中專衛校爲基層社區定向培養鄉村醫生、衛校和醫學院對邊疆民族地區定向招收學生、降低錄取分數線、減免學費等

在人事方面，對鄉村醫生的考核主要看治癒率和防疫接種方面，而不是賣了多少藥、贏了多少利；鄉村醫生由縣衛生系統管理，堅持和完善把鄉醫派駐到行政村的制度，不把基層的醫防保人員完全精簡掉，對鄉村醫生的人員精簡不應低於一（行政）村一（編制）人，並繼續由鄉村醫生負責日常的醫療、防疫、保健和計劃生育，基層的醫療人員/機構不宜私有化，不搞成個體戶、「賺錢戶」。

簡短的結語

現在，可以說，對於雲南藏區鄉村的防疫—醫療—保健工作，主要是應立足於普通社區成員的健康，而不是他們的財富增長和他們所在社區的經濟開發。

首先，已經有可能把經濟—社會—文化—健康—生態的協調作爲新世紀當地醫療制度創新和醫療—保健—防疫服務的起點；

其次，由此出發，思路完全可以是多方位的、綜合的，從長遠來看也是可持續的，而不是重蹈先破壞後修復、先污染後治理的覆轍，從而保證社區關係的逐漸改善和人們生活質量的穩步提高；

再次，雲南藏區（並進而偏遠貧困山區）的基本的醫療—防疫—保健，在一個很長時期內仍然會帶有公共產品和社會福利的性質，也是各級政府必須要承擔的責任，當然，可以在局部範圍內輔之以合作醫療和醫療保險的試點，但是更重要的是應開始在有條件的地方培育多種形式的醫療救濟基金；

最後，所有這些，都是立足在確保鄉村醫療、防疫、保健在現有基礎上完善，常見病、多發病如何得到基本控制，醫療服務如何更深入、更持久。而爲了這個目標，除了硬體方面的基礎建設（醫院建房、購置設備）外，更重要的是對鄉村醫務人員的制度保障和多種形式的業務培訓，對社區成員的健康教育，提供基本的防疫免疫和起碼的醫療保健。

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[1] 本文是作者參加由尕藏加、李實、李濤、路愛國、齊扎拉、王洛林、王小松、魏眾、夏勇、扎洛、周濟、朱玲等組成的課題組對雲南迪慶藏區的實地調查的結果。本文的起草和修改過程一直得到了他們的關照和建議；在一些其他場合，也聽取過何道峰、馬驍、翁乃群、温鐵軍、王超、王曉毅等的批評，一併在此致謝！

[2] 摘自《中共中央、國務院關於衛生改革與發展的決定》（1997 年 1 月 15 日）。

[3] 朱玲在她關於醫療改革的研究中指出：「中華人民共和國成立之時，農村廣大地區嚴重缺醫少藥，居民健康知識和衛生習慣極爲欠缺，地方病傳染病肆虐，人民健康指標屬於世界上最低水平的國別組（World Bank，1997）。爲了扭轉這種局面，政府一方面投資於預防活動，著重預防那些嚴重危害人民健康的流行性疾病和嚴重威脅母嬰生命的疾病。另一方面，整頓已有的衛生工作隊伍，建立基層衛生組織。到 1965 年，農村絕大多數地區的縣、公社和生產大隊都已建立起醫療衛生機構，形成了較爲完善的三級預防保健網。這其中，公社衛生院的運行在很大程度上依賴於社隊財務的支持，大隊衛生室則幾乎完全靠集體經濟維持。衛生室的房屋和器械由大隊投資，流動資金和人員經費主要是生產隊撥付。這些措施使農村缺醫少藥的局面大爲改觀，並最終帶來全國人口健康指標的顯著提高。僅就 1950-75 期間而言，中國的嬰兒死亡率從 195‰ 降到 41‰，人均預期壽命從 40 歲提高到 65 歲（UNDP，1997）。這些平均數雖然不免會掩蓋城鄉和地區之間的差別，但它們的變化趨勢畢竟足以反映農村衛生事業的巨大成就。爲此，中國曾被國際上許多發展經濟學家視爲在低收入水平下通過公共支持實現社會發展的典範（Dreeze and Sen，1989）。（朱玲：「鄉村級衛生室對保障基本醫療保健服務供給的作用」，《中國社會科學》，2000 年第一期。）

「所謂創新（INNOVATIONS），自從熊彼特以來，主要被理解爲去發現已經存在的潛在動力，並在此基礎上，探索把這些潛在動力扣連起來從而產生出新機制的可能性，其中，基層社區的經驗是最重要的參照資源和創新源泉。

「本次調查得到了省、州、縣鄉各級政府和醫療部門的大力支持，也得益自村民委員會和村民自身的大力配合。以下「發現」更多地來自他們的資料或口頭敘述，包括對當地 200 餘人做的各種形式的訪談，如果其中有任何不準確的地方，一概由本文作者負責。

「沒有醫療開支，可以是小病不用看的結果，當然邏輯上也可以是沒有任何疾病所致。醫療開支特別高，反映了小病拖成大病以後再不得已花錢治病的情況。疾病在許情況下是返貧的主要原因，但是關於脫貧的統計大都沒有反映出這樣的問題。

「如朱玲所指出的那樣：經濟改革以來，[全國]縣鄉衛生機構的資金來源中財政撥款所佔的份額逐漸下降，這些機構的運行愈來愈多地依賴於收費。農業集體生產組織解體之後，保留村級衛生室所需要的資金來源就成了問題。衛生室服務的人群一般規模不大，服務收費所得不足以維持其正常運行。絕大多數中低收入水平的村莊，僅僅是爲了維持本村行政管理，就不得不從一個個農戶那裡去索取必需的資金。對這些村委會而言，這種籌資方式與生產隊收入分配時的提前扣除法相比，組織費用要高得多，即便是出於節約交易成本的考慮，也會促使它們放棄爲衛生室籌資。在這種情況下，全國大約 50%左右的村衛生室變成了個體醫療點（衛生年鑒編委會，1999）。還有一些衛生室在形式上承包給了衛生員，但實質上由於村委會放棄了管理而與個體醫療點沒有什麼差別。據此可以判斷，農村集體經濟組織的解體導致了基層衛生機構規模巨大的私有化。這意味着原有預防保健服務體系組織結構發生巨變，它無疑會對基本醫療保健服務的可及性和可得性產生强烈影響。（朱玲：「公辦村級衛生室對保障基本醫療保健服務供給的作用」）

Healthcare and 'People-centred' Community Development

HUANG PING

Observation and Assumptions

A. Observation

1. The paper is built upon the following observations:
   - Yuannan Tibetan Society since the 1950s has never followed the gradual social transformation as the western societies did in their 'classical road of modernisation,' so it also does not simply copy some phenomena that happened in early modernisation process as western societies experienced.

- Comparatively speaking, this report is based on participatory research: the urbanisation in Yuannan Tibetan areas has been developing for 50 years, but it has not created any big – or large – cities. The population in cities has increased but not dramatically so. Meanwhile, with practical policies and institutional arrangements, disease control and health service in Yuannan Tibetan areas showed great improvement in the last 50 years.
- However, because it is located in a secluded-chilly-poverty stricken area, the suitable institutions for local economic-social-cultural sustainable development are not very clear. So the possibilities of promoting social security and improving community health conditions are seriously hindered.
- Worse still, in implementing the centrally-dominated drastic development process and in the general pursuit of shortcut attitudes, let alone problems of environmental protection and social integrity, disease control and heathcare are more adversely affected. Some people in remote areas may have more economic income, but the health situation contrarily declines. There is also the possibility of recurrence of some common diseases, which once were successfully controlled.

2. The questions of common disease control and basic medical service in Yuannan Tibetan areas cannot be analysed using the western approach with its 'classical perspective,' that is not simply as a process of 'industrialisation-urbanisation-densely populated settlement but with retrogressive medical care - spread of disease and deterioration of health.' Comparatively speaking, this report tends to examine this question in the following perspectives:
   - Regarding mode of development, Yuannan Tibetan area as a late-developing area is facing great imbalances in its locality, departments (business and entrepreneurs), and community. This is reflected in opportunity and resource aspects also as well as in result and benefit aspects. Now the 'exploitation of the west' project aims at changing the local difference between east and west, but the elimination or minimisation of the difference between east-west areas is not necessarily wrought by changes in rural-urban difference or central-marginal relations. 'Exploitation of the west' may not necessarily bring about direct benefits to the remote areas like Yuannan Tibetan area, particularly the minority groups in the remote areas. When gradually the cities in the west begin to get on track with the

southeastern coastal areas, the remote areas in the west may be in a more serious marginalised position.

- From the institutional perspective, so far there are no successful models as systemic arrangement or policy frame that are situationally suitable for remote and poor mountain regions in China. Therefore, every poor mountain region and minority area mostly follows the models of development that the coastal areas and big cities employed before. In the modelling and 'catching-up' process, blind and destructive exploitative practices always exist. The people have to pay heavy environment cost, social cost and health cost. These areas cannot achieve rapid industrialisation and urbanisation, but their disease control and healthcare service have to face enormous challenges.
- From the development perspective, the new trend of development is flourishing, attracting investment capital, promoting business, loans and tourism as also greater exploitation (at the same time more concern is put into technical education and traditional farming reform). But the core objectives and measurement of development should not only be established indicators such as average annual income per head or average GDP per head, but it should be practical improvement of people's living quality, including their material and spiritual lives. Theoretically, enhanced investment capital, promoting business, loans, assistance, charity, tourism and education should lead to improved healthcare and increased standards of medical service. However, the latter is not given due importance in the development idea and process. Therefore, in the process of blind or excessive exploitation new forms of environmental pollution and disease are created.

B. Assumptions

Following improvements in the economy and incomes, the standards of medical service and health should also improve. People's physical and mental health should be the important indicator for community development. This report is based on the following assumed agenda:

- Relatively appropriate institutional arrangements and development ideas for remote mountain regions can only be effected through long-time practice and exposure. The officials at different levels and the people have accumulated rich experience in Yuannan Tibetan area in the process of reform and development for more than 20 years. They are adequately equipped to begin an economic-social-cultural-

environmental concerted innovation for the new century.

- No matter how difficult the material bases, we should consider the next strategies for Yuannan Tibetan areas (and other remote areas) with sustainable development and people-centred perspectives. The ideas of development should be multilateral and integrated.
- The huge body of different researches have revealed from their own perspectives that first destruction – including destroying people's physical health – then recovery, first pollution – including polluting people's mentality – then cure, are not only economically costly, but also cause the dissolution of social relations and deterioration of people's living quality.
- Basic medical care and epidemic prevention, which are elements of welfare, should be the responsibility that government should bear; it should not be left to business-oriented enterprises. In the remote mountain areas, when implementing social security system reform, we should focus on social security rather than business-like insurance. This is the important point in reconstructing a community-cooperated healthcare system.
- The most important areas of work in healthcare in Yuannan Tibetan area (now and in the near future) should focus on: how to guarantee and improve medical care, epidemic prevention and healthcare; basic control of common diseases; making medical services more in-depth and sustainable. For achieving this objective, besides basic physical facilities (hospitals, equipment), institutional protection and multi-training programmes provided for grassroots medical workers are more important for educating community members on health, providing epidemic protection and necessary healthcare.

C. Medical Condition

1. Overall sanitary situation of Yuannan Province

Since the 1950s, the medical and sanitary condition in Yuannan Province has shown great improvement. The average lifespan has increased from 35 years in the 50s to 66.4 years in 1995.

2. Several Important Elements

The achievements in the medical and sanitary aspects in Yuannan Tibetan area is definitely greatly related to the success of local socio-economic development. However, we cannot neglect the important element of the appropriately arranged institutions for the Yuannan situation by different governments. These arrangements include:

- Yuannan Tibetan area since 1990 has basically established or re-established village clinics in all administrative villages, village

doctors are serving there, and the province's financial and sanitary departments solve the doctors' salary and benefit problems. Village halls provide the space for the village sanitary centre and doctors' accommodation. Now 100 percent of the villages in the province have sanitary rooms, and basically get achievement in following areas – manpower, housing, equipment, salary, institution.

- The medical care, anti-epidemic and healthcare have not clearly separated from the institutional system in Yuannan Tibetan area. The hospitals in every village town have their protection and healthcare groups and professional workers, and also carry out a lot of disease prevention and women-children healthcare work.
- Yuannan Tibetan area preserves the tradition of Tibetan medicine. Recently doctors practising Tibetan, Chinese and Western medicine collaborated to train a group of Tibetan and Chinese doctors, aimed to ease the tensions caused by inadequate western doctors, equipment and medicine.

Investigative Discoveries

A. The achievements and difficulties discovered in the participatory investigation

1. Achievements

Since the reform, particularly after 1990, medical and sanitary businesses have shown great improvement and 800 village doctors have been trained. Now the three categories of medical care-precaution-healthcare linkage has been basically formed. This is a remarkable achievement in a remote minority area (especially Tibetan). This great success was made possible by the joint effort of different governments, Tibetan officials and people in Yuannan Province.

2. Difficulties

However, we must see that the general education level and basic facilities in the province are lagging behind, the development of economy and society is relatively low, especially in the hilly and chilly areas, transportation is extremely inconvenient. Even though the number of medical workers per 1,000 population is relatively higher than that in the country, actually on an average every medical worker has to serve a rather wide area, especially some remote villages. People live in a poor material environment, so the attitude of 'no need to cure small illness' and 'no ability to cure serious illness' is very common. As a result, small illness becomes serious illness; the adverse cycle of 'poverty causes illness and illness causes poverty' becomes even more obvious.

The expenses are paradoxically different – either no medical expenses or heavy medical expenses (more than 18 percent of the total expense which is higher than the average medical expense of all villages in the country). One phenomenon we should pay attention to is that epidemics are spreading again. They include dysentery, hepatitis, pulmonary tuberculosis and sexual transmitted diseases. This is largely related to the fast pace of development.

B. Opportunities and worries brought by the new reform

1. **Opportunities**

   Reform brings much more development opportunities to the medical business in Yuannan Tibetan area. There is more flexibility in personnel system and medical practices.

2. **Worries**

   This research discovers that there are some worries among the medical workers and people in Yuannan Tibetan area. They are:

   - *Great dissonance between the financial policy requirements and realistic difficulties*: Since the late 1990s every medical unit in Yuannan Tibetan area has been required to predict the deficit in finance, every medical unit has to earn their salary by 10-30 percent. This actually changes the practice of welfare medical healthcare in poor areas. Cases of malpractice are common and the burden of medical expenses increases drastically so that it is very difficult for ordinary people to see doctors.
   - *Difficulties in attracting and reserving the people of talent*: Since the economic and manpower markets become more active outside, it is becoming more difficult for a poor Tibetan area to attract and retain medically trained people in the villages. Also, trimming the structure of medical workers at the village level seriously undermines the confidence of the medical teams.
   - *Not much career-related training to medical workers*: Career-related training was encouraged and promoted for medical workers in Yuannan Tibetan area. However, because of the deteriorating changes in state government financial situation and system, the possibilities of providing free and low-cost training by state government are getting lower. The possibilities of aided training given by the medical institutes in Beijing, Shanghai and Kunming are also getting less.
   - *The separation of pharmacy from medicine treatment creates new tension in the village medical system*: It is apprehended that the medicine manufacturing enterprises and medicine sellers may profit greatly from this opportunity, and it may increase the people's

burden. Following the separation of medical treatment and pharmacy, the standard of medicine is difficult to be guaranteed.

Analysis

1. Institution
   - *Social Economic System*: Since the reform in the 1950s, the importance of medical care and improvements therein in Yuannan Tibetan area is a serious cause for concern. Now the area is equipped with good institutional foundations for better healthcare and disease control.
   - *Reform and new institutional arrangements*: After reform, mainly decentralisation and institutional adjustments have been carried out and it also corresponds with considerations of the local history and situations. Therefore, medical care, healthcare and epidemic prevention provide sustainable development in Yuannan Tibetan area.
   - *Financial system, medical system and institutional installation*: The salary of medical workers are not subsidised by the government; with the simplification of the medical system, pharmacy is separated from medicine treatment; barefoot doctors can no longer practice in the reformed medical system. Therefore, these kinds of great changes directly affect the medical service, epidemic prevention and healthcare system in the community. Here we should know that basic sanitation cannot be run as a business/enterprise, and we cannot rely on the cooperated medication or business insurance. Basic medical care, epidemic prevention and healthcare should be the public goods for the people.
   - *Institutional choices*: Tourism was considered as the leading business to stimulate the activities of other sectors such as agriculture. However, after long time of practice and reflection, it is seen that on the contrary it brings other adverse consequences such as new epidemics, for instance, HIV-AIDS. With the blossoming of restaurants and hotels, it is difficult to maintain standards in sanitary conditions, for example. The sex industry, gambling, drug abuse will bring other serious health problems.

2. Society
   - *Development standard*: According to the social standards of UNDP, for example the average lifespan and average literacy rate, Yuannan Tibetan area has higher social development than other areas in

Yuannan, but it is comparatively not as high as other regions. If we also look at access to mutual trust, social security, community supporting network as the development standards, Yuannan Tibetan area gets better social development base than many other areas.

- *Several relations*: The overall development of the Yuannan Tibetan area is very impressive. However, it also faces the same problems as other Tibetan areas or minority race areas do. For example, relationship (tension) between economic betterment and social deviance, short-term economic effects and long-term social benefit, local development and marginal area exploitation and destruction, foreign economic cultural standard and local traditional religion. From these relations, it mostly involves the adjustment of the new benefit relations in the possible dilemma: it is not only the conceptual questions of 'catching-up' and 'not catching-up.' The so-called 'benefited' (in the content of development) does not include a very important but usually neglected element, that is the good physical and mental health of the people and good medical service that people should get when they are ill.

Kamukhaan: A Poisoned Village

ILANG-ILANG QUIANO

In August 2000, a 10 million-peso criminal libel suit was brought against Dr Romeo F Quijano, long-time anti-pesticide campaigner and president of Pesticide Action Network Philippines, by the Lapanday Development Corporation (LADECO), a banana plantation company operating in Mindanao, Philippines. The case was filed on the basis of an article written by Dr Quijano and his daughter Ilang-Ilang, titled 'Poisoned Lives' which appeared on March 6, 2000 in the Philippine Post. *The criminal complaint, which in case of conviction could carry a jail term of up to six years without any right to a jury trial, drew widespread support for Dr Quijano and his daughter and was ultimately dismissed by the Department of Justice in March 2001, signalling a victory for anti-pesticides activists the world over. (In 1993, Dr Quijano was also sued [the suit was subsequently dismissed] by a transnational pesticide company because his statements against pesticides were published by some national newspapers.)*

In its suit LADECO alleged that 'Poisoned Lives' was 'plainly defamatory.' The article reveals several cases of illnesses and deaths attributed to exposure to toxic pesticides in Kamukhaan village, which is just beside the banana plantation owned by LADECO and located at Hagonoy, Davao del Sur. Dr Quijano's daughter, Ilang-Ilang Quijano, co-author of the article, and the editors and publishers of the Philippine Post *were included in the libel suit. LADECO also charged that the article carried malicious and false imputations that LADECO committed violations of the Labour Code and government regulations on the use of pesticides. Curiously, the* Philippine Daily Inquirer, *which also published a special report containing essentially the same story and corroborating much of the information earlier published by the* Philippine Post, *was not sued by LADECO.*

In a statement answering the libel charge, Dr Quijano asserted that the article in question was based on facts gathered from several visits to Kamukhaan

since 1997, after the village was chosen as a field visit area in an international conference on pesticides and when the situation of the village was first documented by Pesticide Action Network Asia-Pacific. Dr Quijano added that the information conveyed in the article including the illness incidents, were based on actual interviews and medical examinations he conducted on several residents in the area, most of which were recorded on video camera. Several of those who were interviewed were summoned by the company and were made to sign statements contradicting their previous statements recorded on video.

A number of the residents reported that they were intimidated by the company and that the company gave certain favours to obtain the signed affidavits that do not reflect the truth. On the company's claim that there has never been any complaint regarding the adverse effects of pesticides used in the plantation, Dr Quijano pointed out that testimonies gathered by the reporter of the Philippine Daily Inquirer, *which also published the same story, corroborated the information that village residents had presented their complaints repeatedly to the company and to local government officials and that the company has not challenged the veracity of those testimonies.*

Dr Quijano further pointed out that the toxic pesticides which the company had admitted using, are scientifically known to cause the illnessess and other adverse effects which had been observed to occur in Kamukhaan and that people in Kamukhaan are inevitably exposed to these pesticides since the village is immediately adjacent and located at the downstream side of the banana plantation. The company's claim that the pesticides used 'pose no threat to human, animal or plant life in the area' – using as proof negative laboratory results of samples submitted by the company for pesticide residue analysis for just one pesticide which is not even in the list of the several pesticides used by the company – was dismissed by Dr Quijano as a 'blatantly illogical conclusion.'

Dr Quijano also dismissed the conclusion of the company that the findings of the Regional Officer of the Fertiliser and Pesticide Authority (FPA), who supposedly conducted an investigation, 'disproved' the facts mentioned in the article. He pointed out that the Regional Officer was not a health professional and therefore was not competent enough to 'investigate' the illnessess reported and that her conclusions were subjective perceptions that do not negate the objective evidence pertaining to the complaints of the people of Kamukhaan. Dr Quijano also belied the assertion of the company that the pesticides they are using are safe because these 'have been cleared by the FPA,' since 'being cleared' by the FPA is no proof that a pesticide is safe to use and that even the FPA recognises that pesticides pose threats to human health and the environment. This is precisely the reason why there are restrictions and guidelines for pesticides use.

On the company's claim that they have not violated labour laws and that the company have complied with health and safety standards relative to the use of

pesticides, Dr Quijano pointed out that the information on low wages and hazardous working conditions was based on documented interviews with some of the workers themselves and was corroborated by other informants. Furthermore, the hazardous conditions which subject the workers to risks are clearly evident in the photo and video documentation. Dr Quijano asserted that the article 'Poisoned Lives' is trying to communicate the main message that poor and marginalised people suffer because of pesticide use due to profit-oriented cash crop production for the benefit of the rich. He maintained that there was no malice whatsoever in writing the article and that the message being conveyed is a legitimate and important concern for the general public who have the right to be informed. Finally, Dr Quijano declared that the authors of 'Poisoned Lives' have the right to convey the message through the printed medium in a manner that would conscientisise the readers. The article is reprinted here with permission of Pesticides Action Network – Asia and Pacific (PAN-AP) — Editors

The place was so barren and desolate, one would think that it was abandoned, except that the shabby huts and its impoverished inhabitants were impossible to miss. This is Kamukhaan, a community of 150 families in Davao del Sur, Mindanao, Philippines, whose people and their land for the past 19 years have been facing a slow but certain death due to heavy exposure to pesticides. The entry of the LADECO banana plantation situated right next to it in 1981 marked the genesis of poisoning, sickness and poverty. Since then, the village has been cruelly subjected to large doses of pesticides the plantation utilises for its own benefit. Through constant aerial and ground spraying, the people have been in direct contact with these chemicals for years, both their health and environment withering under their deadly mist. And while the perfectly healthy and unscathed bananas produced in the plantation are being shipped off to be enjoyed by foreign countries and major fruit canning industries, the people of Kamukhaan are left to pay the price ....

Kamukhaan was not the wasteland that it is now. As village elders wistfully recall, it was once the picture of perfect prime, a place so rich in natural resources people never knew hunger. Trees and vegetation were abundant, and the seas were loaded with marine life. The villagers who either fished or grew crops for a living always had more than enough to feed their families and sustain quite a comfortable lifestyle. The land where the banana plantation now stands originally belonged to the descendants of the Buloy family, part of the Manobo tribe, who rented the property to the Americans during the American Occupation. Diego Buloy, 71, the only living member of the Buloy family, says: 'They promised to raise cattle in it. They cheated us and

we had never been able to recover it.' The vast acreage is currently being used for a banana plantation by the LADECO company, which from the beginning promised prosperity, a 'banana dreamland' that would change the lives of the people. Now, virtually no trace of their past life remains to be seen. All that's left is barren land, a contaminated sea, and 700 sick and impoverished people breathing in poisoned air.

Since the plantation's expansion in the early 1980s, the people of Kamukhaan have had to endure aerial spraying of pesticides which takes place as often as 2-3 times a month. Pesticides, which the company uses to ensure for themselves pest-free, export quality bananas, are sprayed by an airplane, which sweeps through the plantation and their entire village. Every time a spraying occurs, the villagers smell strong and odorous fumes, which cannot be escaped from, even in the shelter of their own homes. Their eyes sting painfully and their skin itch. Most of them experience feelings of suffocation, weakness and nausea. Alona Tabarlong, 31, elaborates, 'Children playing in the street come in, coughing and complaining that their eyes hurt. The airplane passes our streets, and even when it's far away, the smell of pesticides still reaches inside our homes.' Another villager claims that during aerial spraying, he sometimes gets sprinkled by pesticides and itchy and painful skin lesions promptly appear.

Children and adult alike, who rarely got sick before the plantation came, are now vulnerable to disease. Skin diseases, abnormalities and various types of illnesses are rampant among the villagers. They easily catch fever and constantly encounter spells of weakness and dizziness, vomiting and cough. Many claim to experience all sorts of body aches: stomach aches, backaches and headaches, which are aggravated during the periods of aerial spraying. Several people also suffer various ailments such as asthma, thyroid cancer, goitre, diaorrhea and anemia. Edgar Rodriguez, 31, narrates that 'My skin has these white spots. Sometimes I have difficulty breathing. I am often attacked by severe cough and at times I can't sleep because of it.' Linda Manggaga, a woman in her mid-40s, has a large lump on her neck that she claimed had been growing for a long time now. She believes that her weariness and the growth on her neck had been the effects of pesticide exposure. 'Around 1981,' she recalls, 'I was on my way to sell wood when I smelt strong fumes and fell very ill. Then years later, I discovered this huge lump on my throat.'

Infants are often born sick and with abnormalities, ranging from cleft lip-and-palate to badly disfigured bodies. Several children are born with severe skin abnormalities. Infants dying at birth or shortly after are not rare. When Rebecca Dolka, 36, bore her child, it was lifeless, its body and eyes yellow in colour. 'I didn't expect that the pesticides I inhaled would affect my pregnancy,' she said. Exposure to pesticide also proved to be an impediment

in children's mental and physical development. Children are often behind in their studies, and are often absent in class due to sicknesses.

An example is Lilibeth Hitalia, an eight-year-old child who is constantly rushed to the hospital because of diaorrhea. 'She was already four years old when she started to speak. She has great difficulty in understanding things, and also was born too small,' her mother relates.

A number of adults have also been diagnosed with more serious, terminal diseases such as cancer. Many more have died of various contracted diseases. A village officer, Leonardo Tigaw, testified that in the month of August alone, five people have died because of diaorrhea and fever. Michael Bakiran, 31, said that his mother constantly complained of the pesticide fumes and suspect that she died precisely because of this. 'Her stomach became enlarged, and she became weak. The hospital diagnosed it as a 'complicated disease' and she died two weeks after.' Nanette Rodriguez, 37, narrates, 'Just this month of July, nine people died. Several people have already died and became sick before so we appealed to the manager of the plantation. But he said that they refuse to pay the hospital bills if the sicknesses were caused by our water, and not by the pesticides, even when hospital doctors say that our water supply is contaminated by the pesticides that seep into our soil. That's also the reason why so many people get sick, and spend so much. Others don't even reach the hospital alive.' Apparently, constant deaths caused by diseases ranging from simple to complicated have horrifyingly plagued the people for years. In fact, 'just yesterday' a villager testified, 'a woman lost two of her children.'

Moreover, growth of plant life in the village has also been seriously stunted. When exposure to pesticide started, the coconut trees suddenly stopped bearing fruit so the villagers were left with no other choice but to cut them down instead. 'The chemicals the plantation uses might be good for their banana crops, but on our coconut trees, it is destructive,' says Nanette Rodriguez, a villager. Their soil, too, had become infertile, so growing crops for food and income has now become very difficult. Planting food suddenly wasn't an option they could afford any more. Even grass grew scantily among the place. Raising pigs, chickens and other animals also proved to be very difficult because numbers of them just die every time a spraying occurs. Animals who wander into the plantation or feast on the grass near their property also meet their death. The villagers also believe that their streams have been contaminated too because many animals refuse to drink from it and the animals who do eventually die.

Aside from the aerial spraying, the plantation also ground-sprays their banana crops using chemicals such as Furadan and Nemacur, both of which have been labeled as 'extremely hazardous.' The village people believe that

their underground water supply, 180 feet deep, has long since been contaminated with it. During the rainy season, rains wash over the plantation's land and the pesticide-riddled water flows into the village where it rises up to as high as waist-level. As a result, the villagers who unavoidably wade in and the children who play in it get ill.

An even worse predicament for the village is the fact that the river and the sea, both of which have been one of their major sources for food and income before, have not been spared from pesticide contamination. Their waters, which used to be teeming with fish, are now heavily polluted with chemicals. Fishermen recall a time 30 years ago, 'when we used to garner up to 200 kilos of fish every day. Now we are lucky if we can catch two kilos of it.' They have also observed the regular occurrence of fish kills, when there used to be none. And due to extreme poverty, people eating the contaminated fish cannot be avoided, and they end up getting sick as a result. Complaints have been repeatedly brought up to the plantation owners but the owners refused to claim responsibility in the sea contamination. The fishermen then tried to appeal to provincial authorities and they even took samples of the dead specimens, water, and soil to the town hall, but again their pleas merely fell on deaf ears and no definite action was taken.

With pesticides destroying the natural life in the land and water they were dependent on, the villagers who once never went hungry suddenly found themselves going to bed on empty stomachs.

The 'blondeness' among several children are tell-tale signs of malnutrition and protein deficiency. When being farmers or fishermen alone made survival virtually impossible, most males were forced to work as labourers in the plantation. They are usually employed as drainage workers and pesticide applicators, working in direct contact with the chemicals, wearing little or no protective clothing at all. One labourer narrates that his job involved walking through canals of waste materials, wherein the chemical-laced waters reached his thighs, thus rendering his boots useless. He consequently ended up losing two toes and with a badly infected foot, the treatment of which he had to pay on his own. Another companion of his doing similar work was more unfortunate, and eventually died of cancer of the foot.

Pesticide applicators inject pesticides to the bananas or directly spray it by backpack, some doing it as often as daily. Two labourers who had used Gramoxone as spray were hospitalised, and one of them died. The other workers experience dizziness, weakness, and skin itching, and are absent from work almost once a week because of their illnesses. Edward Rama, who injects BAYCOR and DECIS every week to banana buds, says that he is 'always feverish, experiences stomach aches, has skin that constantly itches, and tires easily.' Jose Antermo, 30, used FORMALIN daily, and he regularly experienced

spells of weakness and dizziness. 'FORMALIN is painful to the nose, and my chest tightens when I smell it. My wife, she lost our child when she was four months pregnant. I think it was because of my job. She washes my work clothes doused with FORMALIN.' Labourers who had served in the plantation for a long period of time became so weak and sickly they had to stop working altogether.

The risky labour these workers are involved with, they ransom for with their health, and yet they only receive a miniscule salary in return. About 45 pesos (less than US$1) a day does it for the average employee who works in extremely hazardous conditions from morning until sundown. 'Sometimes, we receive 90 pesos, if we finish a lot,' says one of them. This small amount of money they receive is way below the threshold income to buy food that would sufficiently sustain their families. Oftentimes, these workers don't receive the medical treatment they badly need because they cannot afford to pay for it themselves. The plantation refuses to grant employees a raise in their salaries and couldn't be expected to pay for their hospital bills. One employee does not even get paid his salary but is given food instead. He claims that he was promised 9 pesos per cubic metre, and for the 6 cubic metres he manages to dig per day, 'I should be given 54 pesos a day but instead I get 5 kilos of rice every week that is supposed to be enough to feed my family of four.' He has tried to complain about this unfair arrangement but, according to him, 'the labour contractor is never around.' Some people, desperate for a living even sell *ipil-ipil* leaves (an ingredient for animal feed) for 2 pesos per kilo and earn the measly sum of 100 pesos a week.

With their health fast deteriorating, their food supply seriously depleted, their land destroyed and with no other source of income sufficient enough, the people of Kamukhaan may not be too far away from extinction, unless they find an effective antidote to their poisoned lives. The plantation is nonchalant and feigns innocence when confronted with complaints about their unsafe pesticide operations, and the local authorities likewise proved to be of no help to them. A village elder says with resignation, 'We've tried, but as much as we want to, we cannot do anything about it any more. It is very powerful people we are up against.'

Would man go as far as to slowly and painstakingly destroy more than 700 lives in the name of profit? Apparently, yes. In a land reeking with disease, coupled with poverty, the survival of the people of Kamukhaan merely hangs by a thread. Through relating their observations and what they have endured throughout the years, they are actually crying for help. Too deeply mired in their state of sickness, poverty and hopelessness, perhaps it is the only thing that they can do. Perhaps we can help in lifting themselves up

from the place that profit-hungry corporations had put them into, and once more give them a glimpse of the life that they once had and deserve.

It is in far-flung villages like Kamukhaan where the picture of globalisation and human greed is most clearly depicted. Unfortunately, few ever seem to take notice, and even fewer who choose not to ignore and succumb to apathy. The victims of suffering and injustice has knocked on our doors. They have presented to us their plight, which clearly, in black and white, reveals the grave impact pesticides use has on people's lives, how it caused the degeneration of Kamukhaan from a natural paradise to that of a living hell. The damage created by tyrant companies can only be undone with the aid of people, who unlike them, value the intrinsic worth of human life over any amount of money or profit. Perhaps by working hand in hand with the people of Kamukhaan in rebuilding their homes and lives, we may be one in our hope in transforming this world nearer to the paradise we want for ourselves, for our children, and for the future. For as long as villages like Kamukhaan exist, the battle against injustice, human greed and oppression is never won.

Competition Promotion and the Prices of Drugs and Medicines

Orville Solon & Eduardo Banzon

The prices of drugs and medicines are considered to be at levels that produce inequalities as well as inefficiencies. Of particular concern are variations across countries in the prices of drugs with the same brand, same maker and same dosage, and price variation locally among drugs of the same type, even among generics. Three solutions are surveyed: having government engage in the production and distribution of drugs, using government procurement, and promoting greater competition in the pharmaceutical industry. Obstacles to competition promotion are likewise discussed.

Public Concerns over the Prices of Drugs and Medicines

The prices of drugs and medicines are considered to be at levels that produce inequalities as well as inefficiencies. In particular, it is argued that the prices of drugs and medicines reduce access to medical care by the poor and reinforce irrational drug use and imply deadweight losses. On these grounds, various policy measures aimed at reducing drug prices have been proposed.

The most popular argument for price regulation is that the prices of drugs and medicines prevent consumers, especially the poor, from accessing appropriate medical services (HAIN 1990). Take the case of hospital care. Drugs and medicines take up 60 percent of the average hospital bill, and the average hospital bill is three times the average monthly family income, (NSO-FIES 1997). Relative to non-hospital services, estimated price elasticities for the utilisation of hospital care ranges from –0.13 for a public facility to –3.0 for privately provided care (Tan 1998). This means that a 10 percent increase in the price of hospital care induced by increasing drug prices will reduce utilisation of publicly provided hospital services by 13 percent and that of private

hospitals by 30 percent. The adverse price response is estimated to be larger for lower income groups.

A related concern is that prices that are not affordable lead to irrational drug use ranging from the use of ineffective remedies to non-compliance with prescribed dosages. Non-compliance is especially notable because it generates the negative externality of drug resistance.

It must be noted, however, that public concerns about access and irrational drug use do not point at price regulation as the appropriate policy response. An effective poverty alleviation programme or demand-side subsidies via social insurance could be equally effective in improving access to drugs by the poor. Innovative treatment protocols like DOTS (Directly Observed Treatment, short-course) in tuberculosis (TB) control may be more effective in reducing non-compliance than setting price ceilings for TB drugs (TB Control Programme).

The third concern is that drug prices reflect mark-ups over the cost of manufacturing and distributing drugs. Since drug companies obviously cannot perfect price discrimination, then the presence of such mark-ups imply deadweight losses (Mascollel, Whinston, Green 1995). This means that what is lost in terms of consumer surplus is larger than revenues from the mark-ups.

The validity of public concern over monopolistic pricing is difficult to establish owing to measurement and information problems. Traditional measures like market concentration ratios are inappropriate for the pharmaceutical industry. The share of the top four companies to total sales have been declining over the years – from 0.52 in 1981 to 0.41 in 1990 (Bolanos and Lao Guico 1992). With new entrants engendered by the implementation of the Generic Drugs Act of 1987, concentration ratios can be expected to be lower in recent years. The problem with concentration ratios is that they measure the overall dominance of a multi-product firm, not the dominance in the market of a specific drug. Patent holders like Pfizer would rank low in overall market share but would obviously have a monopoly in the Viagra market. However, the data to measure market share for specific drugs is not available.

Another approach to validate the exercise of monopoly power is to establish excess profits in the pharmaceutical industry. Should company reported financial statements be considered an unreliable source, one would have to discern profitability based on stocks and bonds markets (Scherer 1993). But in the Philippines, drug companies are not listed. The information needed to directly establish mark-up pricing by drug companies is private to the companies themselves. Ideally, one has to decompose the price that consumers pay for drugs into costs and mark-ups from manufacturing, wholesaling and

Table 1. Retail Prices of Selected Drugs in 1995 (in US$)

Country	Ranitidine (Zantac by Glaxo) 150mg/100 tabs	Amoxicillin (Amoxil by Smith Kline Beecham) 250mg/100 tabs	Captoril (Capoten by BMS) 25mg/100 tabs
India	3	10	*
Nepal	3	10	*
Australia	20	40	13
Bangladesh	33	*	*
Pakistan	39	8	21
Colombia	47	37	64
New Zealand	52	22	43
Mexico	57	*	41
Sri Lanka	63	24	25
Greece	71	*	40
W Samoa	71	30	*
UK	73	27	*
Thailand	74	17	33
Italy	77	*	37
Canada	81	14	*
Malaysia	86	34	54
Zimbabwe	87	24	53
Philippines	95	29	54
France	99	37	44
Hong Kong	119	*	47
Belgium	128	*	68
Netherlands	131	40	43
Germany	149	*	40
Indonesia	150	40	*
Finland	156	*	*
US	169	36	76
Switzerland	284	*	*
China	*	*	*
Latvia	*	18	*
Tanzania	*	*	*

Source: 'Retail Prices in the Asia-Pacific Region,' *HAIN News* No. 86, December 1995.

retailing. Indirect techniques of price decomposition like the estimation of hedonic price equations can eliminate the need for detailed firm level data. But the cost of undertaking consumer surveys to generate data needed to estimate the price components of various types of drugs tends to be prohibitive.

Two Observations on the Prices of Drugs and Medicines

The current policy debate over drug prices revolves around two observations concerning price variation for similar drugs across countries and within the Philippines. The discussions have focused on what explains observed price variations, what the observations imply about the competitiveness of the pharmaceutical industry and what policy actions should be taken.

The first observation is that the retail prices of drugs with the same brand, same maker and same dosage vary widely across countries (see Table I). Take for example a box of 100 250mg tablets of amoxillin (brand name Amoxil) by Smith Kline Beecham. Retail prices are observed to as low as US$8 in Pakistan and as high as US$40 in Germany. The same drug is being retailed in the Philippines for US$29 and in Thailand for US$17.

The second observation is that the prices of drugs of the same type vary in the local market, even among generic drugs (see Table 2). Consider amoxillin again as an example. Among generic products, the antibiotic is sold for as low as Php220 for a box of 100 500mg capsules to as high as Php830. The lowest priced branded amoxillin is sold at Php 759 – cheaper than the highest priced generics. The highest priced branded amoxillin is sold at Php 1800 – over eight times the price of the cheapest generic product.

Alternative Explanations of the Two Observations

Whether or not government should intervene to address public concerns over drug prices and what appropriate policy action should be taken depends largely on how one explains the two observations made earlier. In the policy debate, pharmaceutical companies have stressed cost and quality differences to explain price differences. On the other hand, advocates of public intervention have emphasised international and local monopolistic pricing practices.

With regard to international price variations, three alternative explanations have been offered. One is that after taking into account differences in taxes and regulatory regimes, price differences are largely due to cross-country differences in manufacturing and distribution costs (Reekie 1996). Government subsidies in manufacturing are believed to be what makes drugs

Table 2. Domestic Retailing Prices of Selected Drugs

Amoxicillin 500mg/capsule 100s box in 1998 PhP		
	Manufacturer	**Price**
Low Generic	Axon	220.00
Medium Generic	First Fil-Bio	439.50
High Generic	Unilab	830.00
Low Branded	Victrocin by Boie	759.05
Medium Branded	Termox by Solvang	1273.55
High Branded	Amoxil Forte by Smith Kline Beecham	1810.22
Paracetamol 500mg/tablet 100s box		
	Manufacturer	**Price**
Low Generic	DMLI	12.00
Medium Generic	Pacific	45.00
High Generic	Unilab	74.00
Low Branded	Dolexpel by Morishita-Seggs	87.38
Medium Branded	Cretan by Ethnol	274.20
High Branded	Medicol-A by Unilab	656.15
Rifampicin 450mg/capsule 100s box		
	Manufacturer	**Price**
Low Generic	Axon	440.00
Medium Generic	Pacific	480.00
High Generic	Alman	510.00
Low Branded	Koshmed by Vitalink	577.00
Medium Branded	Rexilan by Am-Europharma	1233.54
High Branded	Fampisec by San Marino	1995.70

Source: Bureau of Food and Drugs

and medicines cheaper in South Asian countries. Cost structures also vary substantially across countries, especially the share of distribution costs. In particular, it is often pointed out that unlike other Southeast Asian countries, the Philippines spends more on sales promotion and advertising. The cost of goods sold accounts for only 50 percent while distribution costs account for 25 percent. The remainder goes to administration, R&D, royalties, interest charges, taxes and profits (Bolanos and Lao Guico 1992). An anecdote used to emphasise the point is that in Manila sales personnel use cars while their counterparts in Jakarta use motorbikes.

Studies show that apart from cost differences, international price variations are determined by differences in demand conditions. Although criticised for not using robust product measures (or baskets), cross-country studies have suggested that multinational pharmaceutical companies practice international price discrimination – that is, companies charge prices equal to what the domestic market can bear (Schut and van Bergeijk 1986). In effect, multinationals charge a mark-up based on domestic demand price elasticities.

But the question that begs to be asked is why international price differences prevail at all, regardless of whether cost differences or price discrimination is the valid explanation. The market response to cross-country price differentials is arbitrage. And the quickest way to make money is to buy low and sell high. But why has this market response not dissipated price differences between the Philippines and the rest of the world?

Consider the case of 100 25mg tablets of Captoril by BMS (see Table I). In 1995 the product was being sold in the Philippines for US$54. In Australia, the same product was retailed for only US$13. Assuming an importation cost of 100 percent (freight and duties included), the landed cost of Captoril from Australia would be US$26. This would leave US$28 for marketing, distribution and profits. But why are Filipino and Australian traders not engaged in arbitrage or parallel importation?

As shall be discussed in a later section, trade barriers exist to prevent international trade from dissipating cross-country price differences. Despite the substantial decline in tariffs on pharmaceuticals (from 15 percent to 3 percent in the last decade), international trade has not produced enough pressure for local drug prices to decline (relative to prices abroad). Non-tariff barriers have effectively shut out parallel drug imports from domestic markets. Specifically, a law designed to protect consumers from counterfeit drugs is now being implemented in a manner that considers parallel imports as counterfeit.

Three similar arguments are presented to explain the second observation concerning domestic drug price differentials. One argument is that there are substantial differences in manufacturing and distribution costs among drug companies. There is a lack of studies on scale and scope of economies but industry profiles suggest that cost differences might be substantial in the area of marketing and distribution (Bolanos and Lao Guico 1992). The components of marketing and distribution costs that reportedly vary substantially among drug companies are advertising, entertainment and representation, and distribution of drug samples.

A related explanation is that domestic price differentials reflect quality differences especially in bio-efficacy – that is, how fast a drug is absorbed, the effectiveness of its active ingredient and the absence of adverse side-

effects. The Bureau of Food and Drugs (BFAD) does not require tests for bio-efficacy. Hence, local manufacturers are left on their own to vouch for the quality of their products. Multinational drug companies use their having passed rigorous tests by the US Food and Drugs Administration (FDA) to differentiate the quality of their products.

The third explanation is related to the implementation of the Generic Drugs Act, which requires the use of generic names in labeling, advertising and prescriptions. In response to this regulation, generic drug manufacturers entered the industry and brand name manufacturers produced generic drug products. Worldwide experience suggests that with the introduction of generics, the average price of drugs and medicines tend to decline. However, recent studies (Frank and Salkever 1995) on individual drugs find evidence that the prices of branded medicines have increased alongside price reductions in generic drugs. This finding suggests that with generics, pharmaceuticals can practice second-degree price discrimination. This means that drug companies use branded versus generic drug products to discern differences in price elasticities and then charge the corresponding mark-ups.

3 Generic Solutions to Reduce Price of Drugs and Medicines

Three generic solutions covering the ideological spectrum have been proposed to address public concern over the price of drugs and medicines. On the extreme left are proposals for government production and distribution of drugs and medicines. At the centre are proposals to leverage existing government procurement of drugs and medicines for price reductions. At the extreme right are proposals to use competition promotion to reduce drug prices.

If drug prices contained substantial mark-ups, then in theory government can exert pressure to reduce prices by going into drug manufacturing and distribution itself. Government owned and operated drug companies can then be mandated to set prices at original costs (or at short-run average costs to recover fixed costs). Private companies would then have to adjust prices in order to keep their market share from being eroded by public enterprises.

But the experiences with public enterprises established for similar reasons in other areas such as in agriculture, the petroleum industry and banking have been disappointing: waste and inefficiencies owing to public subsidies and wage structures that are not anchored on performance. In effect, public enterprises fail to realise their potential as a regulatory instrument largely because of the inability of government to enforce and monitor efficiency mandates. In some cases private sector interests capture public enterprise behaviour.

The second solution involves using government procurement to reduce drug prices. If government had information on costs, it can set a reference price to guide procurement for drugs and medicines used by public health facilities and for reimbursements by the social health insurance programme.

The effectiveness of this solution, however, largely depends on the size of government procurement relative to the drugs market. In 1997, expenditures by local and national health facilities accounted for only 40 percent of total national expenditures (NSO-Phililippine National Health Accounts 1997). But the leverage potential of such spending is substantially less because government health budgets are spent largely on personnel. Moreover, autonomous local government units do more than half of government health spending. The national health insurance programme has the most potential for using procurement as a regulatory instrument. At the moment, however, social insurance accounts for only 7 percent of total national spending.

It should be noted that even if the amount procured by government were substantial, it would require reliable information on drug manufacturing and distribution costs. Setting price references too low will lead to shortages in drugs in government facilities. Setting prices too high will effectively transfer informational rents to drug suppliers.

The third approach is for government to promote greater competition in the pharmaceutical industry by removing trade barriers and facilitating parallel importation. The overall effectiveness of letting parallel imports exert competitive pressures on existing drug companies will depend on the size of price differences here and abroad, the facility with which new drug traders enter and the number of entrants. As suggested by Table 1 and Table 2, the price differentials for certain types of drugs may be attractive to new entrants.

These are technical difficulties with promoting parallel importation that government needs to address. This is discussed in detail in the next section. Moreover, even without these technical issues, competition promotion might not be considered politically attractive. It can be perceived as non-action. And its success is highly dependent on factors outside the control of government (that is, the number of new entrants). A case in point is the failure of oil deregulation to deliver on its promise to lower the prices of petroleum products.

Obstacles to Competition Promotion via Parallel Importation

There are three obstacles to competition promotion that government needs to address. One set refers to existing non-tariff barriers. The second concerns the dominance of a single company in drug distribution. The third has to do

with limited government capacity to provide information on quality and prices as public goods.

Non-tariff barriers. As mentioned earlier, the biggest obstacle to parallel imports is the implementation of the Counterfeit Drugs Law of 1997, which requires the BFAD to distinguish counterfeit drugs from registered locally manufactured drugs, registered imported drugs and unregistered imported drugs. Current registration requirements for drug importers do not cover registered importers bringing in counterfeit drugs. The implementing rules of the law address this requirement by stating that:

> If the unregistered imported drug product has a registered counterpart brand in the Philippines, their product shall be considered counterfeit (Rule 1, Interpretation and Definition of Terms, irr of RA 8203)

Once this definition is amended, then the Counterfeit Drug law will cease to deter unregistered drug importers. However, the next hurdle would be for the importer to meet licensing requirements to be actually able to sell the unregistered imported drugs locally. Requirements for registration include:

a) Foreign agency agreement between the Philippine importer and foreign supplier duly authenticated by the territorial Philippine Consulate;
b) Certification that the manufacturer of the raw material, active ingredient and/or finished product is registered in the country of origin, duly authenticated by the territorial Philippine Consulate, and evidence that the manufacturer meets BFAD standards for local manufacturers; and
c) Certification of free sale of the products in the country of origin duly authenticated by the territorial Philippine Consulate, and evidence that such certificate is issued in substantial compliance with BFAD standards.

These requirements may have to be amended if parallel imports are to be facilitated. For example, requirement (a) must be amended because it limits drug importers to individuals who are agents of product license holders. If one wants to simply purchase the medicines from a third country distributor/retailer, one may not be able to secure a foreign agency agreement.

Requirement (b) and (c) are consistent with the World Health Organisation (WHO) scheme referred to as a Certificate of a Pharmaceutical Product. However, both also need to be changed. In response to the growing international trade in medicines, the World Health Assembly adopted in 1975 a certification scheme on the quality of pharmaceutical products moving in international trade. Called the WHO Scheme, it is a voluntary scheme wherein

countries that sign up can use the regulatory decisions made by exporting countries. The scheme will help importing countries obtain:

- Assurances that a given product has been authorised to be placed on the market in the exporting country; .
- Assurances that the manufacturing plant in which the product is produced is subject to inspections at suitable interventions, and conforms to good manufacturing practices and quality control; and
- Information on the implementation of inspection and control exercised by the authorities of the exporting countries.

Operationally, regulatory agencies in an importing country can ask for a 'Certificate of a Pharmaceutical Product' with the costs of the request charged to the applying drug importer. The Certificate will state whether the product has been licensed for what indications, good manufacturing practices (GMP) and Quality Analysis (QA) controls. The WHO recommends that its intended use by a competent authority in an importing country is for product license, license renewal and extension and/or review.

A document that is much simpler than this is the 'Statement of Licensing Status' which states simply that a license has been given to the product for use in the exporting country.

A third document is the Batch Certificate of a Pharmaceutical Product. This attests to the quality and expiry date of a particular batch of medicines and is intended to accompany a specific batch or consignment of a licensed product. To promote parallel imports, we can have a system where the Certificate of a Pharmaceutical Product with all its statements on GMP and QA controls can be requested from the original country where the medicines were manufactured. From the third country where the parallel importer will procure the medicines, a 'Statement of Licensing Status' and a certificate analogous to the 'Batch Certificate' will be a requirement.

Limited BFAD capacity. Relaxing licensing requirements to facilitate parallel imports will open the domestic market to substandard imports and even counterfeit drugs. This concern brings us to the second obstacle – the inability of BFAD to monitor and test for the quality of drugs. This weakness also helps preserve consumer (and doctor) preference for imported branded drugs since locally produced medicines (branded and unbranded) do not go through the same tests imported drugs undertake.

The Department of Health is mandated to establish standards and quality measures for drugs and adopt measures to ensure the production of safe, efficacious and good quality drugs and devices in the Philippines. This mandate

is implemented through BFAD which must ensure that drugs distributed in the country meet safety, efficacy and quality or purity standards.

How does BFAD operationalise its mandate as provided by law (RA 3720)? BFAD requires any person desiring to distribute medicines to first submit to the BFAD the following documents:

- Reports of investigations which have been made to show whether or not such drug or device is safe, efficacious and of good quality for use based on clinical studies conducted in the Philippines;
- Full list of the articles used as components of such drug or device;
- Full statement of the composition of such drug or device;
- Full description of the methods used in and the facilities and controls used for the manufacture of such drug or device;
- Samples of such drug or device and of the articles used as components thereof as the Department may require;
- Specimens of the labeling proposed to be used for such drug or device;
- Labels that include the name and country of manufacture, dates of manufacture and expiration date; and
- Other requirements as may be prescribed by regulations to ensure safety, efficacy and good quality of such drug or device.

BFAD has the power to verify the validity of all the claims in these documents. This includes spot visits of the manufacturing sites and the conduct of an assay test.

The most crucial requirement is that reports on the safety, effectiveness and quality of the medicines must be based on clinical studies conducted in the Philippines. However, this requirement is not strongly followed as BFAD may license a medicine based on reports of clinical studies done in other countries. Nonetheless, BFAD does require post-marketing surveillance (PMS) for three years of all new drug applications. BFAD calls the PMS a Phase IV clinical trial although this point is much debated. The present design with an arbitrary sample size of 3,000 can be significantly improved.

From the listing above, it can be construed that all one needs for applications for a new drug are paper submissions. Indeed, to hasten the applications of several new drugs that have created a backlog for many years, BFAD now requires paper submissions for drug registration. According to BFAD, no laboratory exams are being done. And to think that the tests that BFAD usually does are mainly assay and solubility tests.

The technical competence of BFAD plays an important role in competition promotion. It will have to ensure that parallel imports are safe and efficacious. Moreover, it will have to effectively provide consumers the information

needed to identify the relative quality of domestically produced drugs and imported drugs, whether branded or generic.

Upgrading BFAD means enhancing its capacity to assess purity, efficacy, quality and safety. It also means strengthening its capacity to monitor the drug chain from manufacturing/importation down to the retail outlet once a drug is approved for the market.

The purity test is easiest to conduct, as it is a mere assay test to measure the chemical composition of the medicines. All drugs should undergo this test. Furthermore, BFAD must do regular purchase/collection of drugs in the market for assays up to two years after registration.

In addition to the assay test, BFAD should do a stability test for all registered drugs. Stability is the ability of the drug to retain its properties within specified limits throughout its shelf life.

BFAD should also be rigorous in labeling requirements, particularly the manufacturer's name, importer/distributor's name, batch number and expiry date. For parallel imports, the Batch Certificate is a crucial document. This helps ensure that counterfeit drugs will not be passed on as parallel imports.

Quality, more than anything else, is a measure of the manufacturing process. With importers, the Certificate of Pharmaceutical Product from the country of manufacture would be sufficient to ascertain quality. For parallel importers, we must find a way to convince mother countries to give this certificate even if the drugs are bought from a third party. In the case of local manufacturers, particularly generic drug manufacturers, BFAD has to expand its capacity to inspect and monitor local manufacturing processes.

With regard to efficacy and safety, drugs should be classified into innovator/patented drugs and generic copies. With respect to generics, the important issue is whether the generic copy meets interchangeability and drug switchability standards. Such standards can be tested by equivalence studies such as bioequivalence, pharmacodynamics studies and clinical trials.

Apart from using these tests to screen for quality, the information produced by such tests must be effectively relayed to consumers and doctors. The current regulatory regime only requires drug companies to meet minimum standards – that is, the purity test. Without having to change the law mandating such requirements, BFAD can introduce a voluntary scheme where drug products are tested for bioequivalence. Medicines that pass such tests should then be marked with a seal indicating higher quality. In effect the seal should help eliminate questions concerning quality differences between imported, local, branded and generic drugs. With the seal of higher quality, the remaining issue that the consumer confronts is price.

Distribution choke point. The third obstacle to competition promotion is the dominance of a single company in wholesaling and distribution. Up to 80 percent of drug companies use the distribution network of Zuellig Pharma (BFAD 1999). A single company also dominates retailing: the Mercury Drug chain represents 60 percent of the retail market.

One concern is that parallel imports can be denied access to the distribution facility controlled by these two dominant firms in order to reduce competitive pressure on its regular clients. But a more serious concern is that potential price gains from parallel imports can be eroded as the dominant distributor and retailer exercise market power by charging mark-ups over distribution and retailing costs.

These two issues bring back proposals for government to establish an alternative distribution network. The open access public health delivery system can be organised as a distribution network composed of hospitals (national, regional, provincial and district) and health centres.

The physical infrastructure and location pattern required of an effective distribution network is in place. What needs to be built is the information and management infrastructure that would allow these facilities to function as a network especially since most of these facilities are financed and operated independently by local government units. Moreover, the pharmacies in these facilities will have to develop the capacity to serve not only their patients but also the general consumer. The pharmacies in government health facilities will have to be transformed into a drug retail chain.

A way for government to avoid having to put up the investment requirements of building an alternative distribution system is to have private concessionaires build and operate the network (or parts of it). Concessionaire contracts should be competitively auctioned. Winners can be chosen on the basis of investment commitments, proposed price caps on critical drugs and possibly even rent.

REFERENCES

BFAD (Bureau of Food and Drugs) Report, 1999.

Bolanos, MS and CS Lao Guico. 1992. A Study on the Market Concentration of the Philippine Pharmaceutical Industry. Undergraduate thesis, School of Economics, University of the Philippines.

Frank RG and DS Salkever. 1995. *Generic Entry and the Pricing of Pharmaceuticals*. Cambridge, Massachusetts: National Bureau of Economic Research.

HAIN (Health Action Information Network). 1990. *Drug Monitor*, 5(2).

Mas-Colell A, MD Whinson and JR Green. 1995. *Microeconomic Theory*. New York: Oxford University Press.

NSO (National Statistical Office). 1997. Family Income and Expenditure Survey.

NSO (National Statistical Office). 1997. Philippines National Health Accounts.

Reekie, WD. 1996. *Medicine Prices and Innovations: An International Survey*. London: IEA Health and Welfare Unit.

Scherer, FM. 1993. Pricing, Profits and Technological Progress in the Pharmaceutical Industry. *Journal of Economic Perspectives*, 7(3): 97-115.

Schut, FT and PAG van Bergeijk. 1986. International Price Discrimination: The Pharmaceutical Industry. *World Development*, 14(9): 1141-50.

Tan, C. 1998. Econometric Analysis of Demand for Hospital Care. Working paper, School of Economics, University of the Philippines.

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Patents vs Patients: AIDS, TNCs and Drug Price Wars

KAVALJIT SINGH

ON APRIL 19, 2001, 39 drug transnational corporations' (TNCs) association, which had taken the South African government to court over patent laws, dropped the lawsuit unconditionally. The case was filed by the Pharmaceutical Manufacturers' Association of South Africa (PMASA), a body representing South African subsidiaries of 39 drug TNCs. The Association challenged the Medicines and Related Substances Control (Amendment) Act which allows compulsory licensing and parallel importing of Acquired Immuno Deficiency Syndrome (AIDS) drugs and other drugs as well.

Compulsory licensing permits the South African government to license local companies to produce cheaper versions of drugs whose patents are controlled by foreign drug companies. Local companies can produce and sell drugs in South Africa after paying a reasonable royalty on sales to the foreign drug companies. By increasing competition in the market, compulsory licensing can significantly lower the prices of drugs. Parallel importing allows South Africa to import cheap, generic versions of drugs without permission from the patent holders. For instance, a South African company can import drugs from an Indian company and then sell them in South Africa. Since the prices of drugs are lower in several countries, parallel imports can help in lowering the prices of drugs. Recent experience shows that both these measures can be helpful in promoting access to drugs at affordable prices.

The South African Parliament passed this Act in 1997. There are 4.7 million South Africans suffering from AIDS. Faced with higher prices of drugs, particularly those related to AIDS, this Act was meant to make available drugs at affordable prices to South Africans. The South African government defended the Act on the ground that providing equal access to healthcare (which also means affordable drugs) is a constitutional obligation. Further, the

government announced that it would use the provisions of this Act as per the rules of the World Trade Organisation (WTO). It is noteworthy that only four members of the PMASA – Merck, Glaxo-SmithKline, Bristol-Myers Squibb and Boehringer Ingelheim – are involved in AIDS drugs, but the remaining 35 members also decided to be a party in the lawsuit against the South African government. Surprisingly, one of the defendants in the lawsuit included Nelson Mandela, who was President of the country when this Act was passed.

Dropping the Lawsuit: No Altruism

It is important to emphasise here that the drug TNCs unconditionally dropped the lawsuit not because of their sudden change of heart or altruistic feelings towards the poor South Africans suffering from AIDS. Rather, it was the result of a sustained campaign by a number of health activists and groups which included Medecins Sans Frontieres (Doctors without Borders) and Treatment Action Campaign (TAC), a South African group started by Zackie Achmat. Achmat is an HIV-positive patient but he consistently refused to take anti-retroviral drugs until they were made accessible to all South Africans. An important dimension to the lawsuit was added when Judge Ngoepe appointed TAC as *amicus curiae* (friend of the court).

These groups campaigned tirelessly to get the drug companies to drop the lawsuit against the South African government. The health activists and groups were successful in spreading the message across the world that drug TNCs have been putting profits before poor people's lives. They highlighted various arm-twisting strategies adopted over the years by the drug TNCs to block attempts by the poor and developing countries to supply cheap drugs to their patients.

Medecins Sans Frontieres launched the global 'Drop the Case' petition that was signed by nearly 285,000 citizens from 130 countries calling upon the drug TNCs to drop the case. The petitioners included people from diverse backgrounds – from slum dwellers in Nairobi to Dr David Ho, winner of the 1996 *Time* magazine 'Man of the Year' award for his path-breaking research in anti-retroviral drugs for AIDS. In the US, students also organised protests within the university campuses against drug pricing and patent regimes. Given the fact that some US universities hold patents on several AIDS drugs (for instance, University of Minnesota holds the patent for Zaigen manufactured by Glaxo-SmithKline and Yale holds patent of Zerit manufactured by Bristol-Myers Squibb), the campaign was instrumental in pressurising the TNCs to drop the lawsuit as well as lower the prices of drugs in the poor countries.

The drug TNCs were really finding it difficult to counter the campaigns launched by these activists and groups. The drug TNCs even tried to force

their viewpoint by raising the spectre of negative economic consequences of dropping the lawsuit against the South African government. They argued that dropping the case would lead to an exodus by the drug TNCs from South Africa and consequently, the entire country may suffer. However, there were few takers of such arguments in both the government and civil society which together fought the battle against the drug TNCs.

In order to divert the attention from the real issues, the drug TNCs also launched a misinformation campaign by arguing that the problem with AIDS in Africa is not due to highly priced drugs but due to lack of health infrastructure including computers; as if lack of computers had caused this pandemic.

For the oligopolistic drug industry, this episode was perhaps the worst ordeal as their international reputation took a severe beating. The drug TNCs had never anticipated such a strong international backlash to the lawsuit. As later admitted by Rick Lane, President of Bristol-Myers Squibb, 'I think we underestimated the capacity to be made villains.'[1]

The Real Motives of Drug TNCs

The drug TNCs opposed the Act tooth and nail on the grounds that it violates the Trade-Related Aspects of Intellectual Property Rights (TRIPS) under the WTO agreement. But this position taken by drug TNCs is erroneous because there are provisions within the TRIPS, which allow governments to take special measures to protect the health of their citizens. Both compulsory licensing and parallel imports are allowed under TRIPS. In fact, a number of developed countries including Japan and the European Union regularly take resort to these provisions.

In fact, the intentions of drug TNCs were something else. The stakes of the drug TNCs were much higher than the market for AIDS drugs in South Africa, which is just one percent of the global drug sales. The drug TNCs were concerned more about the wider implications of this Act. They were apprehensive that if the South African law is allowed to retain its stand, other countries may be encouraged to enact similar legislation. In particular, TNCs were quite worried about the adverse impact of this fallout in the US markets where they earn the bulk of their profits. They feared that if the poor and the developing countries were allowed to buy low-priced drugs, American consumers may similarly demand lower prices. Already, a number of US-based health activists and groups are demanding massive cuts in skyrocketing drug prices.

At another level, the drug TNCs were equally concerned that if AIDS is the issue today, tomorrow it may extend to heart, cancer or for that matter any

other disease. Fearing substantial slide in their profits in the near future, the US-based drug TNCs cartel, Pharmaceutical Research and Manufacturers of America (PhRMA), was the first one to deplore this Act.

The Shady Role of US

In recent years, the US administration has been actively pushing the interests of drug TNCs, particularly the American ones, in several bilateral and multilateral trade agreements. The US administration has been endorsing the enforcement of a global monopolistic regime of patent rights as well as restricting the capacities of nations to go in for compulsory licensing and parallel importing. For instance, the US-Jordan Free Trade Agreement, completed in fall 2000 and expected to be considered by Congress in 2001, sharply limits the grounds for compulsory licensing.[2] The position of the US on the intellectual property rights section of the proposed Free Trade Agreement of the Americas (FTAA) contains a variety of measures that would effectively extend patent terms, interfere with compulsory licensing, and undermine efforts by poor countries to make medicines more accessible.[3] The US has also been the strongest advocate of even more stringent protection for patents under the so-called 'TRIPS plus' measures.[4]

The PhRMA exercises great influence over the US administration, particularly the office of the United States Trade Representative (USTR). In recent years, several countries including India, Brazil, Argentina and the Dominic Republic have been threatened with trade sanctions under 'Section 301' of national trade legislation by the USTR. The threats were issued when these countries failed to comply with the terms dictated by PhRMA members. It is no coincidence that members of PhRMA spent $236 million in lobbying the US Congress and the government between 1997 and 1999. With the help of Joseph Papovich, Assistant Trade Representative of the US, TNCs have been exercising undue influence over developing countries to protect their patent rights. In the words of none other than Peter Scher, Chief of Staff at the Trade Office under President Clinton, 'Joe Papovich viewed his responsibility simply: carry out the agenda of US companies.'[5]

The crucial role played by PhRMA to influence the Clinton administration to threaten trade sanctions against South Africa is well known. Since early 1998, Papovich and other US officials eagerly took up the cause of drug TNCs with South African officials. The Clinton administration also raised the drug TNCs grouse against the Act during the President's visit to South Africa in March 1998.[6] A variety of arm-twisting tactics were used against South Africa to re-amend the Act. In 1998, for instance, the USTR suspended additional benefits under the Generalised System of Preferences, a trade scheme that allows

poor countries to export products to the US at reduced duties. In April 1999, USTR office placed South Africa on the Special 301 'watch list.' US also tried to 'bribe' African countries not to undertake compulsory licensing.[7] The Export-Import Bank of the US announced in July 2000 that it would make $500 million in loans available to African countries each year for buying AIDS medicines, but with the proviso that these loans could only be used to purchase drugs from the US TNCs.[8]

However, the US administration started reversing its stand on this issue in mid-1999, when health activists and groups started raising these issues and turned the heat on during the Presidential election campaign. It was only in the later half of 2000 that the Clinton administration issued an executive order, which stipulated that the US would not challenge TRIPS-compliant policy measures to make AIDS drugs available anywhere in Africa. It needs to be mentioned here that the executive order is limited by application only to sub-Saharan Africa and only to AIDS drugs.

How the Drug Price War Started

The AIDS drug price war started when Cipla Limited, a medium-sized drug company in India, offered a cocktail of three anti-AIDS drugs (Lamivudine, Stavudine and Nevirapine) for an annual price per patient of US$350 to Medecins Sans Frontieres. Cipla, a leading generic drug maker in India, offered this special offer to Medecins Sans Frontieres through a three-tier pricing mechanism, under which the same combination drugs will be offered at $600 per patient per year to governments and $1,200 to distributors. The offer by Cipla created ripples in the international drug industry because the prices of these drugs in the US and other developed countries are between $10,000 and $15,000 per patient per year.

It has been estimated that there are over 30 million patients suffering from AIDS in the world. Most of these patients are poor and, therefore, cannot afford the exorbitant prices charged by the drug TNCs. Fearing an intense competition in drug prices in the coming days because their prices were much higher, drug TNCs launched a massive offensive against the offer by Cipla.

If one goes by the arguments of the proponents of drug TNCs, Cipla had committed an 'unethical' act by lowering drug prices for the poor patients. Last year, Glaxo accused Cipla of infringing upon its exclusive patent rights of Combivir in Ghana. As a result, Cipla immediately stopped supply of its generic version of Combivir drug to Ghana. But now Glaxo admits that it had no valid patent in Ghana and an 'overzealous' company official made the mistake.[9]

Cipla has also been accused of stealing 'intellectual property rights' of drug TNCs. On being branded as a 'pirate' by J P Garnier, chief executive of Glaxo, Yusuf Hamied, CEO of Cipla, replied, 'If we're pirates, (let them) litigate against us...Where is the question of piracy when we abide by the laws of the land?'[10]

In another interview, Yusuf Hamied stated, 'I am not a westerner marketing drugs for western markets. I represent the Third World and its needs and aspirations. I also represent the capabilities of a country with a billion population. Please do not link up the problems of the Third World and India with those of the West. We haven't broken any laws... the main reason for reasonable drug prices in India is the absence of monopoly because of the Patents Act, 1970.'[11] Hamied further added, 'The average cost of the AIDS cocktail in the West is $10,000 to $15,000 per patient per year – not because the drugs are prohibitively expensive to produce; they're not. It is the drug pricing structure imposed by multinational manufacturers, which makes the drugs prohibitively expensive. Secondly, the international patent and trade regime at present seeks to choke off any large-scale attempt to produce and market the drugs at affordable levels.'[12]

Allegations against Cipla are baseless because the company has not violated any national or international laws. In India, the current laws only recognise process patents and not product patents. Thanks to the Patents Act of 1970, the drug prices in India have come down dramatically as there is more competition and the real beneficiary of these measures is the public at large. Cipla has managed to produce these drugs at a lower cost through 'reverse engineering.' Even in the Indian markets, Cipla has drastically reduced its prices of AIDS drugs by over 30 percent to ensure that the poor needy can afford the drugs. Besides, the company also provides the Indian government free drugs for the prevention of mother-to-child transmission of AIDS. But it needs to be emphasised here that Cipla has not indulged in any charity act for the poor people by reducing the prices of AIDS drugs. The company still continues to make profits.

The immediate fallout of the Cipla offer has been very positive. Almost every drug TNC was forced to announce substantial cuts in their drug prices. Table 1 reveals the drastic cuts announced by several drug TNCs in response to the Cipla offer. Merck, which earlier refused to take part in a pilot programme by the UN to provide HIV drugs at lower prices to several developing nations, was the first to offer massive discounts on its drugs, namely, Crixivan and Stocrin. This cut was on top of sharp reductions announced last year by the company. Merck also abandoned its earlier country-by-country price negotiation policy and offered these drugs immediately to any government, charitable organisation, or employer in poor nations. Merck admitted that its earlier policy of country-to-country negotiations failed as few people (less

than 2,000 people in Rwanda, Senegal and Uganda) could avail the lower-priced drugs.

Table 1: The Price War

Drug *(Company)*	US Price	Cipla	Hetero	Latest Company Offer in Africa
Zerit *(Bristol-Myers)*	3589	70	47	252
3TC *(Glaxo)*	3271	190	98	232
Crixivan *(Merck)*	6016	N.A.	2300	600
Combivir* *(Glaxo)*	7093	635	293	730
Stocrin *(Merck)*	4730	N.A.	1179	500
Viramune *(Boehringer)*	3508	340	202	483

Note: Prices are for AIDS drugs per patient per year in the US and Africa offered by drug TNCs and two Indian generic drug companies.
Prices are in US dollars.
*AZT and 3TC.
N.A. – not available.
Source: *The Wall Street Journal*

Following Merck's decision, other big drug TNCs including Roche, Pfizer, Glaxo-SmithKline, Abbott Laboratories, Bristol-Myers and Boehringer-Ingelheim also announced drastic cuts in their drug prices in Africa. Another generic drug manufacturer from India, Hetero Drugs Limited, further intensified the price war by offering a cocktail of AIDS drugs for $347 per year per person. Hetero also tied up with a large South African generic drug firm, Aspen Pharmacare Limited, to distribute drugs in the country once the South African government declares AIDS a national emergency and grants compulsory licenses to make generic AIDS drugs.[13] Already Hetero has received orders to supply a basket of AIDS active pharmaceutical ingredients (APIs) to Brazil and Argentina.[14]

Thanks to competitive pricing by Cipla and Hetero, the international drug industry is going to witness fierce price wars and massive restructuring in the coming days. The drug TNCs will have no other option but to fall in line and drastically reduce the prices of drugs, even in the developed countries.

Fallacious Claims of Drug TNCs Laid Bare

The developments in South Africa have brought to the fore the real motives of drug TNCs, which put profit before people's lives. The present crisis has unveiled the secrecy maintained by the drug industries for decades about their real profits, which are several times more than their actual costs of manufacturing and distribution.

The usual claims by the drug TNCs that their products are highly priced because they make huge investments in research is questionable on several grounds. First, several of the patented drugs were never 'discovered' by the TNCs. Publicly funded universities and research institutions had carried out the initial research and development of several drugs. The National Institutes of Health (NIH) has estimated that in 1995 the contribution of private industry to overall US health research and development was just 52 percent and the NIH alone accounted for 30 percent.[15] In the initial research of AIDS drugs too, there has been substantial involvement of publicly funded research institutions of the US. For instance, the NIH was instrumental in the discovery of 3TC, Invirase, Ziagen, Zerit and Viramune.[16] In December 2000, the NIH demanded $9 million in royalties from Bristol-Myers Squibb for overseas sales of Didanosine, used in the treatment of AIDS.[17]

Further, the drug companies have rarely disclosed to the public the costs of making a particular drug, and the public has little idea of the exact amount spent on research by TNCs. This is despite the fact that governments have been offering generous grants and tax breaks for research and development to the drug industry. A 1998 investigation by the *Boston Globe* concluded that 45 of the 50 top-selling drugs approved in the US between 1992 and 1997 had received government funding at some stage of development.[18]

Even the claim made by the drug TNCs that they are incurring huge losses due to non-compliance of intellectual property rights are not corroborated by facts. The drug industry is one of the most profitable industries in the world. According to an Oxfam report, even prior to the full implementation of TRIPS, operating profits in the drug industry were over 20 percent.[19] Another report by Oxfam reveals that Glaxo has earned sales revenues to the tune of $1.5 billion on Combivir since this product was introduced in the market in 1997.[20] By making an operating profit of nearly $450 million on this drug within three years, the company has reaped a huge largesse.[21] In fact, most of the TNCs spend more money on marketing than on research and a substantial part of their expenditure is geared towards maintaining monopoly structures. To cite a few examples. Pfizer's production costs were 17 percent of the total sales in the year 2000, research and development costs accounted for a mere 15 percent, whereas marketing and other costs was as high as 39 percent, and the company reaped 30 percent profit.[22] While in the case of Glaxo-SmithKline, production costs accounted for 21 percent of total sales, research and development costs amounted to only 14 percent, marketing and other costs registered 37 percent, and as a result, the company recorded a high profit margin of 28 percent.[23]

Even the argument that patents are instrumental in stimulating investments in research and development of drugs does not stand scrutiny. Only 10 percent

of the global research and development is directed towards diseases of the poor.[24] Of the 1,233 new drugs that reached the market between 1975 and 1997, only 13 were approved specifically to treat tropical diseases.[25] Thus, it is the lack of market, not patent protection, which restricts the drug TNCs from investing in research and development on drugs directed towards diseases of the poor. While billions of dollars are pumped each year into research and development of drugs related to obesity, depression, hypertension, impotency, etc.

The Challenges Ahead

The dropping of the lawsuit by the drug TNCs cartel is an important victory for the people of South Africa and the global campaign to make drugs more affordable. Undoubtedly, it has conveyed the message that people's lives are more important than patents. This victory is certain to boost the morale of the people, particularly in the poor and the developing world, to demand medicines at affordable prices. After suffering such a humiliating defeat, it is unlikely that drug TNCs will launch a similar lawsuit in any other country in the near future. With their bargaining power significantly weakened, the drug TNCs would also find it difficult to persuade the US administration to push their agenda in the international trade agreements.

Despite such a positive outcome, it would be a serious aberration to consider this victory as an end in itself. After winning the first round, the real battle for affordable AIDS medication in South Africa has just begun. After working in close alliance with the South African government against the drug TNCs, TAC and other activist organisations should now pressurise the South African government to allow parallel importing and compulsory licensing. Otherwise, this victory would be of little value for the poor AIDS patients. The South African government should launch a widespread programme to provide AIDS medication to its poor citizens. However, this is not an easy task since it requires a fundamental shift from the neoliberal economic policies being pursued by the Mbeki administration.

At the same time, public-spirited health critics are arguing for further slashing of drug prices for poor AIDS patients because there are millions of poor people who cannot even afford the Cipla offer of annual price per patient of $350. This is an issue which requires immediate attention, given the fact that a large number of AIDS patients earn less than one dollar a day.

At the international level, the next battlefront must be Brazil that is fighting against AIDS despite pressures from the drug TNCs and the US government. In January 2001, the US government made a formal complaint to the WTO regarding Brazil's new patent legislation. It is an open secret that PhRMA was

instrumental in pushing the Clinton administration to prevent the Brazilian drug industry from producing reasonably priced generic drugs to support the government-run universal programme for AIDS treatment. The Brazilian government has repeatedly refuted these charges on the grounds that it has only exercised the exemptions granted under Article 31 of the TRIPS agreement of the WTO.

The publicly funded Brazil health programme has yielded positive results and is, therefore, considered a model for AIDS treatment. Brazil has shown to the world how drug prices could be lowered through generic production. Activists and organisations have to put pressure on the US government to drop its impending World Trade Organisation tribunal case against Brazil for producing cheap AIDS drugs for its own people.

The US has also prompted WTO action against Argentina on a number of issues which will adversely impact its policy of making drugs accessible to the poor people. In fact, much of the US emphasis under the just concluded FTAA negotiations was to restrict the possibility of Latin American countries emulating Brazil's successful anti-AIDS programme.[26]

The recent developments in South Africa will have tremendous international ramifications. This episode is likely to shift the balance of power in favour of the poor and the developing countries. Now the onus is on these countries to take advantage of this case and enact national patent legislation protecting their interests while demanding suitable changes in the international trade agreements. In particular, the developing countries must demand a comprehensive review of TRIPS, including reduction in the duration and scope of patent protection for medicines that are essential for public health. The real challenge, therefore, lies in resisting and reversing the international agreements related to patents that were introduced at the behest of TNCs. It is high time that the primacy of national health policy over international agreements, including the WTO, be restored.

In the light of these developments, the Indian government should reexamine its commitment to amend the Indian Patents Act. Successive Indian governments have assented to amend the patent laws to conform to the regulations under the WTO. A monopolistic patent regime will have serious implications for the poor in India because drug prices will rise phenomenally. One needs to remind policymakers that in spite of lower drug prices, still over two-thirds of India's population is unable to afford drugs.

By bringing highly technical issues into the public arena, this episode has clearly exposed how TRIPS and the concomitant patent regime can adversely affect the lives of AIDS patients in the poor and the developing world. Universal health programmes and other public funded interventions notwithstanding, it is also necessary that monopolies in the drug industry be

dismantled so as to ensure that crucial drugs are made accessible to poor patients at affordable prices.

NOTES

1. Quoted in Gardiner Harris, Aids gaffes in Africa come back to haunt drug industry in the US, *The Wall Street Journal*, April 23, 2001.
2. Robert Weissman, AIDS and developing countries: Facilitating access to essential medicines, *Foreign Policy in Focus*, Vol.6, No.6, February 2001.
3. Ibid.
4. Robert Weissman, 'Free Trade' and medicines in the Americas, *Foreign Policy in Focus*, Vol.6, No.13, April 2001.
5. Quoted in Helene Cooper, Rachel Zimmerman and Laurie Mcginley, AIDS epidemic puts drug firms in a vise: Treatment vs. Profits, *The Wall Street Journal*, March 2, 2001.
6. South Africa's bitter pill for world's drug makers, *The New York Times*, March 29, 1998.
7. Robert Weissman, op. cit.
8. Ibid.
9. Glaxo withdraws charge, *The Hindu Businessline*, April 24, 2001.
10. Cipla dismisses Glaxo 'piracy' allegation, *Indian Express*, March 14, 2001.
11. A cocktail that cures, *The Times of India*, March 1, 2001.
12. Ibid.
13. Gauri Kamath, Aspen could give Cipla tough fight in South Africa, *The Economic Times*, March 16, 2001.
14. Anju Ghangurde, Hetero takes anti-AIDS battle into rivals' turf, *The Financial Express*, March 11, 2001.
15. Patent Injustice: How world trade rules threaten the health of poor people, *Oxfam Briefing Paper*, February 2001, http://www.oxfam.org.uk/cutthecost/patent.pdf
16. Ibid.
17. Ibid.
18. Ibid.
19. Ibid.
20. Dare to lead: Public health and company wealth, *Oxfam Briefing Paper*, http://www.oxfam.org.uk/cutthecost/dare.pdf
21. Ibid.
22. Implausible denial: Why the drug giants' arguments on patents don't stack up, *Oxfam Policy Papers*, April 2001.

23. Ibid.

24. Oxfam, op. cit, February 2001.

25. Ibid.

26. Robert Weissman, op. cit, April 2001.

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They dared to be doctors

The story of Gonoshasthaya Kendra, Bangladesh

Aditi Chowdhury

Doctors are traditionally people who treat the ailing and try to cure diseases. The family doctor of bygone days was not only a healer of the body but also of the mind, the heart, indeed, of life. He was the friend, philosopher and guide, helping solve family problems and often 'helping out', the overworked father's chessmate, the harried mother's listener, the daughter-in-love's confidant, the wild son's advisor. There was an even chance that he would leave behind a part of his wallet than take something away in his pocket. But that was before making money from the poor and the sick became the rule, the standard in the practice of medicine and the yardstick to judge professional greatness and competence. The Mammon empire conquered the world of men of medicine, almost, but not quite. There are some remarkable exceptions in isolated pockets of this Mammonic empire. In a poor corner of the world, a group of doctors adopted the citizens of their country as their family and have been working with indomitable spirit and courage against all odds to make their lives worth living.

They dared to be doctors is a tribute to this group of men and women who have tried selflessly to return to the practice of medicine its former honour and prestige that has been tarnished through centuries of misuse.

Introduction

Bangladesh was born on December 16, 1971 amid tumultuous celebrations. But as the last tune faded and the final retreat sounded, the citizens of a newborn country sat up to take stock of what the future held. Needless to say, they found the prospects bleak and daunting. On the one hand the people had attained true political freedom after centuries of colonial rule and decades of being a vassal state in an independent country – the relentless amassing

of precious resources of the East by West Pakistan, and the subjugation of its people by the military regime was the reason the people had risen in revolt in the first place to demand regional autonomy and finally fought a bloody war to gain independence. The balance was weighed down heavily on the other scale by the fact that the coffers had been completely cleaned out, hunger stalked the country with more than 80 percent of the population living in absolute poverty, the status of women was among the lowest in the world, productivity was extremely low despite Bangladesh's rich alluvial, fertile lands and water and sunshine in abundance, rural Bangladesh was steeped in feudalism with concentration of land in a few hands, and consequently a landlord-merchant-bureaucracy nexus exploited at will; an uneasy truce existed between Muslims and Hindus, with communal forces ever ready to rear their ugly heads; floods and famine ravaged the land at regular intervals, education was negligible and healthcare almost nonexistent. For the masses, true freedom was still a distant dream.

It was in this situation that small groups of people, fired by idealism and the euphoria of freedom, initiated different programmes for rural reconstruction and development, to educate the masses, to provide healthcare facilities, to improve the status of women. Many of these programmes failed or had to be abandoned for various reasons – lack of finance, conflicts of ideology, and the simple inability to fight the landlord-merchant-bureaucratic mafia being the major ones.

Gonoshasthaya Kendra (GK) is among the few which managed to withstand the pressures and establish itself. The leading light of this movement was Dr Zafrullah Chowdhury, whose vision still guides and inspires the organisation, to what degree, we shall see in the following pages.

Following the Rainbow: The Vision of People's Health

In March 1971, when the people living in the eastern wing of Pakistan launched mass resistance against brutal repression by the military, a group of Bangladeshi doctors living in Britain, Zafrullah among them, returned to their country to provide support and succour to the *muktijoddhas* (freedom fighters). The team of doctors set up a mobile hospital in Bisramganj, and went to work with a will, operating out of tents and bamboo huts. By the end of the war, 'Bangladesh Hospital' had grown to 480 beds, local village girls had been successfully trained as nurses and paramedics and the doctors had performed innumerable surgical feats in the tents which were their operation theatres.

By early 1972 the hospital had moved and was operating from three houses in Dhaka abandoned by west Pakistanis. The doctors from Britain had gone

back, only Zafrullah remained. He and a handful of young men and women who had joined his team during the war, with little or no knowledge of rural Bengal but romantic visions of a sylvan idyll coloured by the literary reflections of Bengal's great poets, with no material resources except a profound commitment to a free country, decided to transform and revolutionise their land.

At the end of the day, the group would sit together and passionately debate what could be done. Through this exercise grew a proposal to provide basic healthcare to the rural masses. When the people of the locality began coming in for treatment, an outpatients' department was opened. The debates would centre around the question of whether their responsibility was over with the end of the war and the attainment of freedom. They would then discuss some more, looking into what was happening around the world to create a basic model for Bangladesh.

But it was far from easy, says Dr Qasem Chowdhury of those trying times. 'Around April-May 72 we gave our proposal to the government because we wanted them to try it out. The then health secretary looked at it and put it away saying our proposal was very good but not feasible. We sought permission to try it out.'

The papers gathered dust in government offices while the group continued to run the Dhaka centre and running after bureaucrats to get the proposal approved. 'One day Zafarbhai was very disheartened. He told me, "Qasem, they won't let us do anything good. I'm going back to England." I said, "will you abandon your country on the words of a mere secretary? At least talk to the head of state!"' The doctors requested another secretary in the PM's secretariat to set up a meeting with Sheikh Mujibur Rehman, and when he heard their proposal, welcomed it warmly. 'He told us, "I cannot do everything on my own. I need all the help from people like you. You do it one place, what's wrong?"'

The Prime Minister, however, had one stipulation. They could not continue with the name Bangladesh Hospital as it sounded official. This was a bitter blow to the team of youths as at that time everything was Bangladesh – Bangladesh Misthanna Bhandar, Bangladesh Cloth Store, this and that. The Sheikh smiled and told them, governments don't run sweet shops. But a hospital is identified with the government. He approved Gonoshasthaya Kendra from a list of three names, informing them at the same time that the treasury was empty so they would not get any financial help.

With the blessings of Bangabandhu (friend of Bengal) as Sheikh Mujibur Rehman was affectionately known, and little else but a bagful of dreams, a tenacious determination to do something for the country, and a large supply

of drugs – medical aid consignments shipped months previously but which had arrived after the war was won – the group set to work with rare zeal.

In the beginning the few toiled for just what they called *pete-bhate* or, literally, food for work. Only their meals were taken care of, and even then some days they went hungry. Those who were in a position to, got food from home and shared it. And they mulled over the next question, where should they strike roots? Many sites across the country were inspected, but they finally settled for Savar. There were several strategic reasons for the choice:

- The land belonged to a doctor friend's family which they were getting for free; with no money in the coffers, the offer was a boon;
- It was just 35-odd kilometres from Dhaka and proximity to the capital was an added advantage;
- There was no health centre or hospital in the neighbourhood, only a small dispensary. So the field was wide open for an experimental healthcare system;
- And, finally, in the light of their experience in Bisramganj and perhaps inspired by the 'barefoot doctors', they were keen to train local village girls as healthworkers. (By then they had become aware of the deep divide that existed between the rural population and city-bred, western science trained doctors, and they hoped to bridge this gap with the help of these trainees.)

However, this last desire was not without pitfalls. Savar was in a Muslim-dominant area with a majority population of around 85 percent and, in the early-70s, Muslim families tended to be very conservative, generally keeping women and girls indoors. The doctors hoped to overcome the problem this posed for their recruitment drive by enlisting the help of women students of the nearby Jahangirnagar University.

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The Savar land was overgrown with jungle, a spreading *kathal* (jackfruit) tree near the dirt track which ran alongside offering welcome shade. There were no paved roads. The Christian Organisation for Relief and Rehabilitation allowed the doctors the use of a vehicle on Sundays, and they would drive down from Dhaka to treat patients under the *kathal* tree. Volunteers from an organisation called Service Civil International came every Sunday to clear the wild growth in return for a midday meal. The doctors had their stock of drugs while friends provided food. And their days were full of amazing experiences. Qasem recalls:

'One day Zafarbhai and I were watching the men clear the forest as we talked. Father Tim had given us some tin sheets and we were looking for a good place to put up a shed, when an old gentleman came and stood behind us. Dressed in *lungi-kurta* and a cap on his head, it was obvious he was affluent. "I want to help you," were the first words he uttered. We were taken aback, but I said just give us your blessings, you're like our father. He said, "Mere good wishes don't help good work. You need money, I want to give you some." We thought he would give us 100-500 taka as many people had been doing, so we said we would be glad to accept it. The man withdrew a bundle of 100-taka notes from his pocket, a full 10,000!

'Both Zafarbhai and I became shaky. The experiences with the Razakars and others during the war were still fresh. We wondered what kind of trap this was. Wearing a cap at that! So Zafarbhai with great presence of mind said so much money, it won't be right to take it here, we have an office, come there tomorrow. The gentleman said he knew our Dhaka office. We became even more nervous! Was he a spy? He probably sensed our predicament, for he said "don't be afraid, you are like my son," and invited us to walk with him to a corner of the field. He took us to a car with a woman sitting inside. He said that every Sunday for that past month he and his wife had been observing our work.

'He came to our office the next day and gave us the money. When we asked his name for the receipt he said he wouldn't tell us because if the information got around, people would queue up every day outside his house and most were bogus. We said we had to give him a receipt but we would keep his name a secret. He was Abdul Khaleq, owner of Lalbagh Chemical Company, a very old established industrialist family of Dhaka. He came again one day and gave us another 20,000. Then every Id he would give *qurbani* and send a whole animal to us. "A feast for your boys and girls!" he would say.'

There were many other benefactors whose generosity helped GK to carry on. And through this the doctors would sit writing project proposals, trying to get funds from various sources. Their main goal was providing primary healthcare to the people. But from the very first they had taken some firm decisions which they still feel were the right ones: first, they were taking help at that time but one day they would have to be self-reliant and they would work towards that; and second, they would do nothing for free.

So even in the early days under the tree, they would charge the patients eight annas (16 annas =1 taka). And people would pay. Then when they moved to more permanent premises after the sheds were constructed, they would

treat patients at the clinic once a week and visit the villages in the surrounding area the other six days. 'We did surveys, got to know the people, sought their opinion on our work. There is not a single village where a hut stands whose courtyard's dust has not covered the seat of Zafarbhai's or my pants. We've visited every house,' Qasem says.

By then the team had grown to 22 members – ten men, four of them doctors, and 12 women – working and living under one roof. All of them were single and they took great care not to cause idle talk or gossip. One morning they found anonymous scurrilous handbills and leaflets pasted all around the area. They called a meeting of the villagers to seek their advice. After all there were women and girls from these very villages in their team. The response was encouraging and the villagers told them to ignore the posters. Later, whenever anything similar or out of the way happened, they appealed to the people who were never lacking in support.

Tackling the problem of women

The biggest challenge that faced them was recruiting trainees from among the village girls. It seemed they just could not be convinced. Sandhya Roy narrated her experiences.

> 'It was difficult. It took us years. We were looked down upon in the village. We entered the villages with our heads uncovered, accompanied by men. The villagers regarded us as little better than prostitutes, and streams of abuse dogged us wherever we went. The men wouldn't even let us enter the villages sometimes. They would say we were bad women and would corrupt their wives and daughters. The abuses were really hurtful. They would say no one would even bury us, we were so far gone. It took long and sustained effort to overcome all these barriers and finally gain the acceptance and trust of the people.
>
> 'We would hang around for hours under the scorching sun waiting for a mother-in-law to fall sleep so we could have a whispered conversation with the daughter-in-law in the cookhouse. Snatch a few moments under trees when they fetched water. If we were noticed we would be chased out. But we would return again and again. We would talk to them, teach them by the ovenside, sometimes for half an hour, sometimes less, whatever time we could get. The women here cook the evening meal in the late afternoon, after their lunch. We would talk about family planning, about childcare about so many things. Social problems, their specific burdens.'

It was from these everyday experiences that they learnt about the real situation in society, about the status of women. It was at the end of each day when everyone sat together drinking tea, that they talked about their daily encounters, the iniquities of life, and tried to find solutions to the pervasive problems. 'One woman came to us with massive injuries, her husband had beaten her up for not bringing dowry. In our sheltered middle class lives we were not even aware that such things ever happened. We would offer facetious advice. Why do you insist on staying with your cruel husband? "Leave him? Where will I go?" she would ask. "Why, back to your parents." We thought it was such an easy solution.' And so they gradually discovered how difficult, how impossible it was for a married woman to leave her husband or return to her own family. Perhaps her parents were too poverty-stricken to take on the added burden. Maybe the father had married many times over and the stepmother would not welcome the 'prodigal' daughter. Besides, society would not accept it. And the woman had no education, no skills, no way she could live on her own and survive.

Health insurance

Meanwhile the village surveys were complete and it was decided to launch an insurance scheme. The four doctors knew nothing about insurance but went ahead anyway, charging every family 2 taka a month, 24 taka a year. Within a few months there was chaos, the villagers accusing GK of unfair practice – charging a flat rate for rich and poor. Zafrullah apologised and sought the people's advice on how to rectify the error. The villagers helped GK conduct another survey and each village was divided into three groups, according to ability to pay.

However, the initial enthusiasm for the insurance scheme soon petered out with many people moving away, mainly the poor. Yet at the end of the year, large crowds besieged the clinic demanding medicine even when they were not ill. The doctors were flustered till the answer dawned on them: the reason for the first move was inability to pay and for the second the fact that many who had not needed to visit the clinic during the year came to claim their money's worth.

Since the doctors themselves did not understand insurance too well, they had been unable to convey its purpose convincingly to the villagers. So again, after discussions with villagers, it was decided to introduce a registration fee at differential rates for the different groups, and an additional charge for each clinic visit. That system is still in place though premiums have gone up in the 26 years of the insurance scheme.

INTERVIEW: Dr Zafrullah

There was this girl. Very bright and frisky. But she wouldn't learn anything. Her trainers, masters were indignant. They wanted me to send her away. But each time she said forgive me, next time I'll do better. Finally during one showdown, she said give me a last chance. I immediately seized the opportunity and told her 'I'll let you stay on the condition that you learn to cycle.' She said 'that's no work, that's fun.' Then I found she had turned the whole thing into a game. She was ordering everyone around, 'help me mount, hold the cycle, give me a push, I have to learn fast, I've been punished...' Everyone got into the act and helped her. Not only did she master the art within a few days, she got all the girls eager to learn. She first told them you haven't been asked, I have been punished. But then gave in and helped them.

They would ride around the compound but wouldn't go to the villages. One day I found all the girls huddled together with strained faces. What happened?, I asked. They said Hoshna had disappeared. Hoshna was a teacher at Nari Kendra. She was married. I asked disappeared means what? They said she had gone to her village cycling and after that they couldn't find her. 'The villagers have killed her. We went to the village and they smiled mysteriously when we asked after Hoshna. They said how can a woman ride a bike.'

How could a grown woman disappear? I was puzzled. I asked them if they had checked her house. They said her husband was there so they couldn't go in the afternoon. Anyway, finally she was found peacefully sleeping in her own bed, tired out from the long ride. All the village women said they wanted to learn cycling too. In fact they told her to wear salwar-kameez, not sari.

The woman was around 25-26, no children. Most of our girls are not married, around 17-18. I told her she would have to go to Shimulia village, where they had murdered one of our workers. So four-five of them set off on their bikes. I had told them nothing would happen, but I was worried so an hour later I followed them on foot. The village was a den

Learning From the People

For the doctors and healthworkers of GK it appeared that each day they were learning something new, lessons taught by the very people they had come to provide succour to. In 1974 Savar Gonoshasthaya Hospital was set up with aid from Oxfam and NOVIB and several sub-centres were opened at the Union (administrative unit; several villages form a Union, several unions a district) level. Over time the doctors observed that mothers would bring children to the clinic only when they were seriously ill. When questioned, the mothers said they never had any money as their husbands always had something more important to spend on.

of rogues. There were two mosques. The more the people sin, the more temples and mosques they build. When I arrived in the village there was a lot of activity.
The village heads gheraoed me. 'Doctor, you haven't done a good thing.' 'What have I done,' I asked. Women cycling, it's evil, they said. I said women cycling where, in the cinema? 'No, they said, in the village. 'Oh! They must be girls from Dhaka,' I said. No they are GK girls, we know. We're waiting for them to come back, we won't leave them.' The atmosphere was charged. I had to quickly think of a way out to defuse the situation.
I latched onto Hajisaheb and asked after his mother. She had undergone an eye operation. I asked where was the surgery done, in Dhaka? How did he take her there, made her walk? He got agitated. He had taken her by bus, he proudly announced. By bus? I was aghast. 'So many men must have touched her. You will burn in hell, Hajisaheb,' I said. The rival mosque men were enjoying the exchange and Haji's discomfiture. 'Why didn't you tell us Haji. If you can't afford a car, we would have made arrangements. It's your mother after all!
'

I reminded them of the time when Muhammad was injured in battle and women carried him away from the battlefield. The women were on horseback, not in a bus where body contact with men is inevitable. 'If your mother's honour was not compromised when she travelled by bus, what's wrong with cycling? They don't come in contact with men and they can get their work done fast.' The mullahs thought about it for a while. Their face is unveiled, they said. 'Should I ask them to wear burkhas,' I asked. No, covering their heads will do, they said.

This was how we handled many a potentially explosive situation. That day, anything could have happened. The mullahs were spoiling for a fight and determined to teach the girls a lesson. We were lucky.
Our story is a story of a struggle. Our people have been murdered and tortured by the villagers and again these same villagers have given us shelter and food. That is how we survived.

From these experiences germinated the concept of Nari Kendra. From the very first Zafrullah was determined that one day women in Bangladesh would be independent, free of the yokels that bound them. That was his vision and it was this vision that he transmitted to his colleagues and coworkers. Nari Kendra was meant to provide women a space where they would come to be aware of their rights as well as the many ways and forms of their exploitation; it would offer them means to become economically independent; teach them how to care for their children; and above all learn to have pride and confidence in themselves as women.

The challenge was taken up gently, with sewing classes, the 'traditional' women's work. And while they sewed, they were given lessons in nutrition with demonstrations of the commonly grown greens and vegetables of the

region, taught the food value of each part – the leaves, stems, roots, flower and fruit – to equip them to take better care of their children. There were classes in hygiene and social healthcare. There were also adult education classes where the women were taught some basic maths and to read and write in Bengali.

For the early 70s, this was a significant, in fact, almost a revolutionary move. In the orthodox society of the times women were so completely oppressed that they themselves had ceased to believe they had anything to offer the world. Completely weighed down by social and religious sanctions, they believed women were born without rights and privileges. Added to this was blind superstition. For instance, they would not accept that the greens they could pluck from the roadside could be rich in minerals and vitamins like the expensive vegetables from the market. They ill-treated daughters and spoilt sons. It took long years to convert them, to give them confidence in themselves.

Sandhya's own initiation to GK is quite interesting. She lived in a neighbouring town and had just finished high school. She and her friends were intrigued by the happenings in Savar and would often go over to talk to the women healthworkers, accompanying them on their village rounds. 'I did not understand much then,' she says, 'but I liked it, a window in a huge van, stopping here and there, passing out pills.' She began doing odd jobs for GK till one day she just stayed on. It was much later that she completed her intermediate, and then graduated. From filling out insurance forms at the reception counter, she moved from job to job and now heads Nari Kendra.

What drove her to join GK? 'We were young and we were free,' she says. 'It was our country and we felt we could take on any challenge,' For more than 25 years she has done just that. Does she have any regrets, any thoughts about marriage, did she like living alone with no family. 'GK is more than my family. When I was young I was too busy to think of marriage,' she retorts candidly. 'Now I have a little time, I'm too old to think of marriage.' But the real reason that put her off any relationship was seeing the abject despair and helplessness of women in the villages she visited.

She glosses over the early years when there were days they ate nothing; when they spent the night drenched and shivering because a storm had blown away their tin roof and the few items of spare clothing; when villagers shooed them away hurling abuses; when they were rationed just a mug of water because the tubewell was too far off. 'Sometimes when we were really very hungry, I'd ask my parents to send us some food.... We could bear it all because we were free,' she says.

What she enjoyed most in those early days was the tea-and-talk sessions at the end of a hard day's work. Everyone would gather around and Zafrullah

INTERVIEW: Noorjehan

Member of a GK microcredit society in Techna in Cox's Bazaar, on the changes in her life after the advent of GK

Insahallah, now we all know how to sign our names. Before we felt embarrassed going out now we are free. Before we had to seek permission from our son-in-law, husband to go out, now we don't do so. Now we have our own money. Before we had to ask for pocket money. Now I send my children to school and take them there. I decide. Before this couldn't have happened. There are lots of changes. Before we were ignorant now we are aware. Before when Dulalbhai came we would hide from him, now we talk to him, he's like an elder brother giving us good advice.

GK gave us saplings which we have looked after for so many years. They have grown into healthy trees. My husband, son all help in looking after the trees. The trees belong to all of us. They give us shade, fruit and kindling. And oxygen. Each person needs oxygen from three trees. All the trees had been cut in Bangladesh. Now GK has again given us back our trees. Many officials have come and gone, Qasembhai, Dulalbhai, Abdulbhai … but the trees remain. When we are not here our children will have their trees.

and Qasem told them about the problems of the poor, of the country while the others would each narrate their experiences, share their agonies and satisfaction. 'It was then that I first learnt to think of people before myself. We always thought we would study, get jobs, have families, enjoy ourselves; that we could also do something for others was a novel idea. They taught us where our responsibilities lay. That there were differences in society which had to be eliminated.'

There were many minor incidents which opened their eyes to the real world they were in. One day, when treating a woman suffering from severe malnutrition, they gave her the stock advice of eating eggs, fish, meat, greens, good food. The woman insisted on being given vitamin pills instead. 'We laughed when we narrated this, for we were completely unaware of its import. We thought the woman was joking, and as she had become a specialist now she doesn't need our treatment.' Zafrullah asked them where would the woman get the 'good' food when the answer suddenly dawned on them. That there were people in the country who actually did not get two square meals a day.

So they brainstormed. How can they help out? Tell them to keep a couple of hens or ducks. They could eat the eggs, or feed them to the children or sell them. Not having land they couldn't grow grain, but they could plant a gourd seed which would spread over their roofs and eat the leaves. Or pluck the many nutritious greens growing wild which were rich in vitamins and

iron. And that was how their own lessons in the properties of greens and vegetables began, their teachers, Zafrullah and Qasem. They would collect seeds from the wild and distribute them to those who needed them most. They would tell them which plant was good for eyesight, which for bones and so on. And gradually they learnt to be discerning. The papaya tree grows straight so needs very little land and its fruit, both raw and ripe, was nutritious. Creeper greens could grow over the roofs of the huts. And many such things.

She talks about the aftermath of the Babri Masjid demolition in India on December 6, 1992. She was in Cox's Bazaar when riots erupted in several places across Bangladesh. 'I was encircled by my colleagues. I felt no fear going out because they were all with me.' Unknown to her, her colleagues in Savar went and picked up her teenaged nieces from her parents' home and kept them in GK till the violence had blown over. 'In times of trouble, everyone here shares your woes as part of a family,' she says. Her precious free time she spends tending to the plants in a small patch of land that is her very own. Sometimes some plants die when she is too busy to look after them.

The school for children was started soon after, then cooperatives for microcredit. It started with mahila samitis (women's groups), then the savings scheme, and then the insurance scheme. The healthworkers travelled from village to village, observing and learning even as they informed the women, and later, the men, about poultry keeping, about easy growing plants that were health foods, about hygiene and preventive medicare.

The women came together in monthly meetings to understand each other better. GK tried to find out what their real and felt needs were, what they thought about the contemporary social situation, whether changes were necessary, and also conveyed what they wanted the women to know. Initially 10-12 women in a meeting was a large number. Then the men started joining in and today GK organises combined annual meetings which is attended by thousands. Even while local social problems are discussed, GK invites resource persons from other parts of the country, other NGOs and they have group discussions on contemporary issues. The women are lively participants in these meetings today.

However, GK was not satisfied with just economic empowerment of women. They wanted the women to be much more, to 'storm the male bastion.' So workshops were set up for welding, carpentry, fibreglass, bakery, concrete moulding and all employed mainly women. These workshops have a few permanent employees while trainees are taken on in batches and after two years they are offered some financial help to set up their own businesses.

GK's efforts to train Bangladesh's first woman boiler operator became a cause celebre. Though Jamila qualified in the examinations, she was refused her

commercial operator's license five times, till GK went to court, appealed to the President and finally won the case.

Tariq-ul Islam talks about the celebrated case. The issue is not how many boiler operators have been produced. The issue here is breaking an almost impassable barrier. 'GK fought for this and ultimately won. You might think it's a small thing. But GK fought and no one else has ever done so. Jamila is just the name of a poor village woman. But to establish her rights, GK even invoked the Constitution. No NGO would do it,' he says.

GK has several women drivers, press workers, chemists, in fact, women in every sphere of its activity. Women constitute 80 percent of GK's workforce. Education is an integral part of all the training schemes. For two hours a day, the trainees attend classes, learning to read and write, mathematics, contemporary history, health and nutrition, and other subjects that are deemed relevant for their blossoming.

Family planning

GK's vision was providing integrated and comprehensive basic healthcare to the most disadvantaged of the country and it went all-out to achieve its aim. An integral part of this programme was making women aware of their reproductive rights and the advocacy of fewer and spaced out pregnancies for improved mother-and-child health, which is the foundation of public healthcare. It took years of hard work to train healthworkers and to gain social acceptance, but GK's resolve did not waver even in the face of the greatest adversity. A significant incident demonstrates this determination. It was in 1974, soon after the catastrophic famine which had taken a toll of hundreds of thousands of lives. UNICEF launched a project in Bhatshala, on the banks of the Brahmaputra, where wheat was provided to villagers and in exchange they had to grow vegetables in their backyards. By that time GK's healthworkers had achieved a fair amount of renown for their work in conducting tube ligations as a method of family planning and UNICEF offered them funds for such a project in Bhatshala. GK agreed on the condition that UNICEF also fund follow-up services for two years. The GK staff went into it in a big way, working like maniacs.

In the meantime, as part of the ongoing global campaign to drastically limit population growth in the third world, USAID provided funds to Bangladesh for family planning with the stipulation that it be delinked from public healthcare, as was being done in other countries of Asia, Africa and Latin America. When UNICEF reworked its Bhatshala project accordingly to include USAID's incentive package for doctors, midwives, and the people undergoing sterilisation, just like what had happened in other third world countries, the GK staff protested and stopped work. They did not want to have any part in

'demeaning the dignity of the poor, in commodifying their health.' (Similar campaigns in countries such as India, Nigeria, Brazil – to name a few – triggered a savagery in complete violation of the human, sexual and reproductive rights of couples, which have been extensively documented.)

UNICEF, however, was unable to carry on without the introduction of the incentive package as the government had agreed to it and was forced to abandon GK's project. While the staff continued their round-the-clock work on the project, GK appealed to other donor agencies for funds to complete the two-year followup and Oxfam and NOVIB came to their help once again. At the end of the first year, local people came forward and asked GK to set up a clinic because, they said, they had never seen any other organisation providing such dedicated service. The people donated the land on which GK constructed its second Bhatshala project.

Now GK has several hospitals and clinics spread across the country where health is part of a community development exercise. One healthworker looks after a population of about 5,000. There is a sub-centre nearby for 25,000 population, while the hospital provides secondary care. That it has succeeded in providing basic health services is apparent from a comparison of demographic statistics with the national average. Unofficial statistics compiled in areas where GK has been working for some years show an appreciable decline in the overall death rate, and in infant and maternal mortality, which are far lower than the national average.

Apart from this, GK's contribution has been the demystification of medicine and taking it to ordinary people. It has been able to successfully prove that healthcare professionals do not need to have expensive university degrees, but with proper training, dedication and commitment ordinary rural women can cater to the needs of the masses of poor people in the country, a lesson that can be replicated in all the third world countries desperately in need of healthcare. It played a pioneering role in exposing the drawbacks of certain injectible contraceptives such as Depo-Provera, and, its ultimate success, gave Bangladesh a drug policy that many an advanced society could be proud of.

A Dream Realised: The Period of Consolidation & Controversy

By the 80s, GK was well-established. It had been able to provide comprehensive healthcare to a section of the poorest of the poor rural masses and was gradually expanding its activities. But the founders of GK were not happy. Since the late 70s, they had been hamstrung by the lack of medicines, the prohibitive costs of antibiotics and life-saving drugs. Essential drugs were not

available in the hinterland, in villages and suburbs. Ampicillin cost 8 taka when the dollar was Rs15.

That was when GK decided to intervene and through its efforts, the same drug can be had today for 2.50 taka, at a time the value of the dollar is 51 taka! In the same period, prices of other commodities have gone up by 200 percent or more. Says Tariq, 'This was a significant contribution. Today, of course, campaigning has stopped and the free market has diluted the drug policy. But still we have a drug policy. In Bangladesh no other NGO or anyone has ever staked their future to fight for the poor majority.'

The GK team under the leadership of Zafrullah had worked out a proposal for a national drug policy for Bangladesh whose salient features were:

- All drugs had to be produced and sold under their generic names;
- Brands would be banned;
- Local pharmaceuticals would have first option on production;
- There would be strict quality control; and
- No drugs outside a list of essential drugs drawn up would be allowed into Bangladesh.

The storm of controversy this policy generated when it was introduced has been well documented. The Drug Policy was one of the first issues Gen. H M Ershad dealt with when he took power in a bloodless coup in 1982. No third world country had ever dared to so completely challenge the pharmaceutical lobby, strongest among the TNC lobbies in the world. The US and three other G7 ambassadors in Dhaka called on the president and threatened to cut off aid, Ershad was warned on his first state visit to the US, but the Drug Policy went through. Till then, only the Philippines had a policy on generic drugs; the advocate of such a policy for Sri Lanka, Prof. Seneka Bibile, was mysteriously killed just when it was on the threshold of coming through and his death put the lid on the policy.

The Bangladesh Medical Association, whose members were beneficiaries of TNC largesse, was up in arms, GK property was torched, its staff assaulted. But the policy went through. It is still in place today, though the open market and globalisation has led to its considerable dilution. And Bangladesh, which ranks among the lowest of countries in most categories of development, has been able to provide its people an essential ingredient for improved quality of life which perhaps no other nation has been able to do.

GK paid a heavy price for daring to stand up for its principles. It became pariah among the majority medical fraternity and was isolated in the NGO community for 'collaborating' with Ershad. Ironically the most vocal detrac-

tors of GK are today hand-in-glove with Ershad and the fundamentalist parties of Bangladesh.

In the early 80s, medicines for TB, diaorrhoea, leprosy which were not available, were to be freely had in the black market at Mitford, at two or three times the original price. So Zafrullah decided GK had to produce some essential drugs. They had not thought about a full-fledged pharmaceuticals but were aware for a long time that there was a massive scam operating in drugs. They would write cover stories in the monthly *Gonoshasthaya* on cough syrups, vitamins and other such pills and placebos. They were keen on producing hospital drugs, but had no knowledge or experience about their manufacture. 'The more we read the more we were stunned to realise the largescale exploitation in the name of pharmaceuticals. We found that medicines were selling at 13,000 times their cost of production. Imagine the profits and profiteering!' says Qasem.

They learnt about transfer pricing and other related things and became determined to produce cheap drugs. But there was a catch. Cheap drugs would be taken as B-grade medicine. So they decided to go in for a proper pharmaceutical concern that could compete with the multinationals, and produce quality products. Donors agreed to provide seed money to start a company, and production began in 1981. GK Pharmaceuticals today employs 157 people, 130 women among them. Their production meets around 5-6 percent of Bangladesh's needs. In recent times, sales have been steadily picking up and the company is also making a reasonable profit.

Moving Ahead: Expansion & Confrontation Again

The history of GK has always been stormy and consequently exciting. In 1990 GK and Zafrullah were again involved in another nationwide controversy, this time over a national health policy. This time the policy directly targeted the greed of the medical fraternity, advocating, among other things, banning of private practice – an extremely lucrative proposition – for government doctors and teachers in medical colleges. Medical practitioners who would be affected if this proposal came into force were up in arms, and the opposition parties were quick to take up the doctors' cause. The protests finally culminated in bringing down the Ershad government, and put the draft health policy in cold storage.

Community ownership

In 1990 GK deepened and widened its health service, taking it down to the ward level. The community health centres they envisaged would be run by the people themselves. In the present socio-economic situation in the coun-

try, it is necessary to have such basic community service. The logic behind the move is that if the people can profitably run mosques, primary schools, why not community health centres? GK is now engaged in providing management training and technical help to communities where these centres are being set up. But funds continue to be a problem and they are studying ways and means to overcome this.

People's university

With the setting up of its Gono Biswabidyalay at Savar in 1998, GK saw the realisation of a long-cherished dream. The university, while following the conventional syllabus – or else students will not get their practising registration – adds on a social content. The students are taught health economics, social aspects of health, and related subjects to make them competent, socially sensitive doctors. They visit villages, see for themselves the poverty and deprivation, the special kinds of diseases the rural poor are more prone to, information which no medical textbook provides. In this way the syllabus comes alive, more vibrant and effective. It is a difficult exercise and GK is not sure how successful it will be.

The motivation of setting up the university was the same spirit which brought the Gono Pathshalas (people's school) into being. GK knew that poor children are unable to go to school because just when a little girl reaches school-going age, she begins her stint with the household chores. She babysits her little brothers and sisters when the mother is working. By the time she is 7-8 years old she goes with her father to the field to work or to take his lunch or to the market with him to keep shop. So GK settled for a trade-off. The children were given lunch, the parents told that at least one meal would be taken care of.

What today is Food for Education in Bangladesh, is what the World Food Programme started. But way back in 76-77, GK applied to the WFP for the wheat, pulse and oil meant for vulnerable communities, which it supplemented with greens and vegetables, and fish or meat once a week. That took care of the malnutrition among children. The children were eager to learn and the system went on well for some time. 'But the minute the government launched Food for Education, WFP told us they could not give us the rations anymore, it had to go through the government. So government schools now have this facility and we couldn't hold onto it. We went back to the villagers and told them the situation,' says Qasem. GK is hopeful that if the government goes beyond its own schools to provide food to all schools in the country, the system can be reinstated in GK schools. However, Qasem adds, the problem is more deep-rooted.

'The government takes an idea, but does not adopt the ideology behind the idea. What the government is doing now is that if a child has 75 percent attendance in school, the family is given his share of wheat. The family sells the wheat and buys rice or whatever so the child's malnutrition is not cured. And schoolteachers have got involved in corruption over disbursement of rations. Ultimately it's a failure.

'What we did is invite the mothers to cook for the children. We have 300 students now. So with 10 mothers coming in every day, all the mothers were covered in a month. They would make *rotis* and we found innovative ways to use the opportunity. For instance, if it was an arithmetic class, the students would be told to divide the *rotis* into piles of say 10 each. The next day it was piles of 9 *rotis*, and so on. So they learnt the numbers in a useful way they could understand and learnt the tables that way. And remember them.

'This is how we changed our methodology for more meaningful teaching. At one time we would tell the children to bring their cattle to graze in the GK grounds. So those who couldn't come to school because of chores could do so. This of course we were not able to continue.

'Our attendance level is still high today and many parents now are keen for their children to study beyond class V. They pester us to increase our classes up to VIII but we don't have the funds. We tell them we have to keep bad teachers for less money. So what we did is make arrangements with local high schools where we provide books and the children study free. Many schools oblige us, others are unable to for various reasons.

'Like this many students have passed their matriculation, there are a few graduates, and even one or two postgraduates. Around 10 percent of our healthworkers now are former students of Gono Pathshala, from really poor families. Last year there were five graduates. We invited them all and gave them a reception. Now we say that any of the students clearing their school leaving exams will get a job with us.

'Unfortunately, now what is coming in is what is called functional literacy. World Bank sponsored. Many NGOs have got deeply involved in this. So two streams have appeared: functional literacy for the poor and formal education for the rich. We never went into non-formal education. We provided literacy to adults but never NFE.'

Non-formal education is exclusionary; it does not allow the poor to rise above their station even if they have the ability but is meant for the rich. And herein lies the difference that GK has with several other NGOs and the philosophy of foreign aid. Bangladesh survives on international aid which by

its very nature is exclusionary, creating deeper divides instead of bridging chasms.

Conclusion

The strengths and successes of GK have been discussed above. But there is an all-pervasive feeling in the organisation that despite phenomenal growth it is stagnating. One of the failures of GK is the high turnover of employees in recent times. The main reason of course is the high salaries that are being offered today by other organisations. In fact, job advertisements openly ask for GK-trained healthworkers and they get priority over everyone else. This is a massive drain on GK's own resources.

The reaction to this contentious issue is quite divergent within the GK management. Zafrullah feels that those who want to leave should be allowed to do so. He is not willing to compromise on GK's principles, the values that have taken the organisation where it is today. And an important principle is to pay salaries on par with what the government can afford. So GK salaries are marginally over government payscales, unlike other NGOs where staff salaries are closer to private sector remunerations which are far higher than what the government gives or, indeed, can afford. Another reason is linked to their first principle of self-reliance. GK does not want to be caught in a position of not being able to meet the salary bill if funds dry up. This is a very real problem with funding agencies all over the world drastically slashing even pledged aid.

Qasem's stand is more moderate. He does not like people leaving, but he is happy that those he has trained retain their dedication and sensitivity wherever they go. Employers time and again call up to thank GK for their excellent training. But like Zafrullah, Qasem does not believe in compromising on principles to retain staff.

However, GK's Director of Health Tariq-ul Islam feels that there is a need to downplay ideology. He believes that the ideology and vision which inspired GK's founders have no place in today's world where money is among the strongest motivating forces. Besides, GK has grown so big that the handful of oldtimers just cannot cope anymore in imparting either ideological training or participating in community sharing which had been a constant feature of the earlier years.

Says Dr Islam, 'When people are hungry, ideology means nothing. There are 10-15 people who have left, who cry every time they meet me. They earn much more but they are not happy. They have no job satisfaction. When I ask them why did you leave, they say we wanted to marry. In GK it is difficult to work if you are married and have a family. Expectations are very high and

ordinary men and women cannot live up to it. When I tell them is it only because of marriage you've taken on another job, they say GK is not the world, there's a society beyond this.'

It is not only the world beyond GK, he says. 'GK is also known as a very hard taskmaster and many people cannot take it. Yet our workers are industrious, hardworking and they have the confidence to handle any situation. It's been demonstrated in the emergencies. GK workers are always the first.' But he still feels GK has got into a rut and some ruthless decisions need to be taken to put the organisation back on its feet.

One of the strongest criticisms GK has had to contend with is of 'collaboration' with the military regime of Gen. Ershad on Bangladesh's drug policy. But GK's founders are quite unfazed. They had first presented their proposal to then Prime Minister Zia-ur Rahman, who had turned it down for fear of rocking the aid boat. Their tenacity in pushing through the drug policy in the face of fierce opposition which went as far as arson and death threats is all the more laudable when one looks at what is happening in the third world today over AIDS.

Thailand and South Africa which have the highest numbers of HIV positive sufferers in the world, were threatened by the US with trade sanctions if they went in for local manufacture of certain generic drugs that would cut costs by as much as 70 to 95 percent. When issuing the threats, the US and drug companies were careful not to invoke WTO rules for Article 31 under TRIPS allows for compulsory licensing of generic drugs. But even after the Clinton Administration magnanimously allowed Thailand, and by extension other third world countries, to manufacture cheap AIDS drugs, that country did not follow it up fearing renewal of sanctions.

It is especially ironic in the context of the murky politics that engulfs Bangladesh today. Part of the very opposition which had ostracised GK for collaborating on the drug policy, which gave Ershad a fresh lease of tenure and which used the GK sponsored health policy proposal a decade later to bring about Ershad's downfall, shares the same platform with not only Ershad, but with other fundamentalist groups including Sheikh Mujibur Rehman's killers. The last is even more ironic, for Begum Khaleda Zia is the widow of the man who arguably was the first to broadcast independence of a free, secular Bangladesh.

And secularism is what GK has fought for since its inception. Says Tariq: 'GK fought it. Went to the villages talked about it again and again, were beaten and killed but still went back. Other groups were scared off by vested interests. But GK stood steadfast. And today the funny thing is that in 1993 when the fundamentalists raised their heads and began attacking all NGOs, even BRAC and Grameen Bank, not a voice was raised against GK, though GK has

made it amply clear they have no love for fundamentalists. They know that GK has unequivocal beliefs even if it is against them.'

This is where we leave GK, which on the threshold of a new millennium is moving to work in the war-ravaged Chittagong hill tracts in a bid to embrace communities which have been left completely in the cold for centuries. On their terms.

People's Charter for Health

PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world — a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

The HEALTH Crisis

Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us. – A voice from Central America

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened,

as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE's CHARTER FOR HEALTH

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than

ever an equitable, participatory and intersectoral approach to health and health care is needed.

- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors. The demands presented below provide a basis for action.

Health As A Human Right

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

Tackling the broader determinants of health

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand radical transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.

- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.

- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and overconsumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.

- Reduce over-consumption and non-sustainable lifestyles — both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.

- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-Centred HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drug policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.

- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

People's participation for a healthy world

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.

- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a *People's Charter for Health*.

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000.

The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health movement can gather and other networks and coalitions can be formed.

AMENDMENT

After the endorsement of the PCH on December 8, 2000 it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

The section on War Violence, and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

JOIN US – ENDORSE THE CHARTER

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the *People's Charter for Health*.

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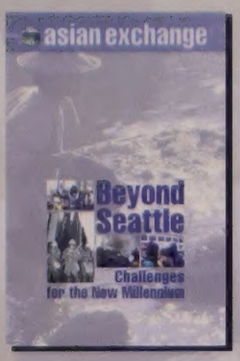

Beyond Seattle: Challenges for the New Millennium

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With an Introduction by *Harsh Sethi*.